

IMCI *workshop proceedings*

REACHING COMMUNITIES *for* CHILD HEALTH



*Advancing PVO/NGO Technical Capacity and
Leadership for Household and Community
Integrated Management of Childhood Illness
(HH/C IMCI)*

Baltimore Maryland
January 17-19, 2001

A description of the Household & Community IMCI Framework is available
in English, French, and Spanish on the following websites:
www.coregroup.org, www.basics.org, and www.childsurvival.org

A document explaining the framework in detail, entitled
"Reaching Communities for Child Health and Nutrition: A Framework for Household and Community IMCI",
April 2001, by Peter Winch et al, is available on all of the above websites.

IMCI WORKSHOP PROCEEDINGS

*Reaching Communities for Child Health:
Advancing PVO/NGO Technical Capacity and Leadership
for Household and Community Integrated Management
of Childhood Illness (HH/C IMCI)*

**Baltimore, Maryland
January 17-19, 2001**

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ACRONYMS

BASICS	Basic Support for Institutionalizing Child Survival
BHR/PVC	Bureau for Humanitarian Response/Office of Private & Voluntary Cooperation
CBC	Communication for Behavior Change
CBHSS	Community-Based Health Surveillance System
CDC	Centers for Disease Control and Prevention
CHC	Community Health Committee
CHP	Community Health Promoter
CHPA	Community Health Promoter Association
CHV	Community Health Volunteer
CHW	Community Health Worker
CICSS	Community Initiative for Child Survival in Siaya
CORE	The Child Survival Collaboration and Resources Group
CMCF	Co-Management and Co-Financing
CRS	Catholic Relief Services
CSTS	Child Survival Technical Support Project
EBF	Exclusive Breastfeeding
FCHV	Female Community Health Volunteer
FFH	Freedom From Hunger
HH/C IMCI	Household and Community IMCI
HIS	Health Information System
HIV/AIDS	Human Immunodeficiency Virus/Autoimmune Deficiency Syndrome
IAWG	Inter-Agency Working Group
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illness
JHU	The Johns Hopkins University
JSI	John Snow, Inc.
LAC	Latin America and the Caribbean
MIHV	Minnesota International Health Volunteers
MIP	Multiple Incentive Plan
MOH	Ministry of Health
MSP	Multisectoral Platform
NGO	Non Governmental Organization
OR	Operations Research
PAHO	Pan American Health Organization
PCI	Project Concern International
PD	Positive Deviance
PDI	Positive Deviance Inquiry
PDQ	Partnership Defined Quality
PLA	Participatory Learning and Action
PVO	Private Voluntary Organization
SECI	Sistema Epidemiological Comunitario Integral
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHP	Village Health Promoter
WHO	World Health Organization

Executive Summary

Representatives of over 40 private voluntary organizations (PVOs)¹, colleague organizations, and key donors met in Baltimore on January 17-19, 2001 for a workshop entitled “Reaching Communities for Child Health: Advancing PVO/NGO Technical Capacity and Leadership for Household and Community Integrated Management of Childhood Illness (HH/C IMCI).” The CORE Group organized this workshop with the support of BASICS II to enhance the capacity of CORE PVOs to take greater leadership in advancing the work of HH/C IMCI at national and district levels.

A great deal has happened since September 1997, when participants of the First Global IMCI Review and Consultation Meeting recognized the critical importance of the community’s role in IMCI. Since then, PVOs with years of experience mobilizing communities have participated in key international meetings and on the Inter-Agency Working Group (IAWG) for household and community IMCI in addition to further documenting and sharing their experiences with one another.

The driving force of this workshop, and one of its most promising outcomes, was the development of a dynamic operational framework for community IMCI. It provides PVOs with a clear structure for assessing programs, planning future programming, and advocating for the resources necessary to fully operationalize HH/C IMCI.

But this product could not have emerged without the documentation, analysis, and correlation of the rich field experience from PVOs gained from working to promote child survival activities for the past two decades. Much of this valuable information is captured in the presentations related to the framework itself and to the several crosscutting issues:

community mobilization, sustainability, and the scaling up of successful programs for the benefit of larger populations.

The HH/C IMCI framework establishes a multisectoral platform for community health work, acknowledging that many sectors contribute to health and recognizing diverse community priorities. Building upon this multisectoral base, the framework describes three requisite elements, or means of working within communities to improve health outcomes for children and their families. These elements target the many influences on health promotion and care-seeking behavior:

Element 1: Improving partnerships between health facilities and the communities they serve

Element 2: Increasing appropriate, accessible care and information from community-based providers

Element 3: Integrated promotion of key family practices critical for child health and nutrition

These elements and the multisectoral platform form an operational framework that can be used as a communication and planning tool by PVOs, government, and the donor community. It highlights the three important sources of preventive information and care: public health facilities and their services, private providers based close to the community, and individuals and households. In establishing these elements as interlinked and requisite, a higher standard was set—to assure that full implementation of HH/C

¹The terms ‘private voluntary (PVO)’ and ‘non-governmental organization’ (NGO) will be used interchangeably throughout this document to refer to private non-governmental organizations engaged in community-based international development programs. The term PVO customarily refers to a US-based NGO.

IMCI strives to connect all providers that exist within a community and engage families for better health through all points of influence. Though elements may be phased in over time, programs that currently target only one aspect (e.g., work with health facilities) miss important opportunities to fully influence the health of a community.

Inherent to all elements are the crosscutting issues of community mobilization, sustainability, and the scaling up of successful programs for the benefit of larger populations. Presentations by participants, representing PVO projects in Africa, Latin America and Asia, demonstrated the wealth of experience PVOs bring to the realization of full HH/C IMCI. The presentations clearly illustrated the overriding truth of HH/C IMCI—that projects designed with community input will be as varied as the communities they serve. The framework, however, can be

readily applied to each project or to each district or subdistrict situation, a testament to its flexibility and usefulness as a tool for understanding HH/C IMCI. It is hoped that the framework will be a tool to enable PVOs, governments, and donors to work together to influence positive health practices and to reduce morbidity and mortality.

A description of the framework is available in English, French, and Spanish on the following websites: www.coregroup.org, www.basics.org, and www.childsurvival.org. A document explaining the framework in detail, entitled “Reaching Communities for Child Health and Nutrition: A Framework for Household and Community IMCI”, April 2001, by Peter Winch et al, is available on all of the above websites.

Proposal to Accelerate Implementation of Household and Community IMCI

Background

Over the past two years, 35 private voluntary organizations that are members of the Collaboration and Resources for Child Survival Group (CORE Group) have worked together to develop a collective PVO response to strengthen their role in the implementation of IMCI. Much has been accomplished during this time frame. Members of the CORE Group have participated in IMCI policy, planning, and evaluation meetings held at global, regional, and national levels. This has enabled the PVO community to provide a community-based child health perspective in policy dialogue with Ministries of Health, UNICEF, WHO, PAHO, and the World Bank. The PVO community has taken a lead in the development and pilot testing of IMCI training for volunteer and auxiliary health workers. PVOs have contributed tools and lessons learned to the development of Household and Community IMCI (HH/C IMCI), based on years of child survival programming and evaluation. PVOs have worked within their own organizations to advocate the importance of this strategy in mainstreaming these concepts throughout their diverse and numerous field locations worldwide. This effort has helped accelerate the number of countries dedicating resources to IMCI, especially to HH/C IMCI, improving family and community practices in relation to child health.

Implementation Framework for HH/C IMCI

To further accelerate implementation of HH/C IMCI, the CORE Group analyzed their successful experiences in the promotion of child health at a workshop on HH/C IMCI January 17-19, 2001. During this workshop, the participants developed an implementation framework for HH/C IMCI.

This framework enables implementers and their colleagues to better communicate and plan public, private sector, and household interventions that can improve child health and reduce mortality and morbidity. It does so within the overall guidelines of the HH/C

HH/C IMCI is the optimization of a multisectoral platform for child health and nutrition that includes three linked requisite elements:

Element 1: Improving partnerships between health facilities and the communities they serve.

Element 2: Increasing appropriate and accessible care and information from community-based providers.

Element 3: Integrated promotion of key family practices critical for child health and nutrition.

IMCI strategy established by UNICEF, WHO and its partner organizations.

Proposal

Through voluntary effort, PVOs can use this framework immediately to continue increasing the quality of child health work they are already doing with their partners at community, district, regional, and national levels. However, this meeting demonstrated that much more is possible at the national level, based on the CORE Group's successful collaboration at the U.S. level in establishing a common vision, exchanging tools and strategies, and mobilizing public support for HH/C IMCI.

In order to expand implementation of HH/C IMCI within countries to additional communities and districts that are most at-risk and in need of this strategy, PVOs and NGOs seek the following types of support from donors, host governments, and other colleague agencies:

Develop tools/guides/materials to support operationalization of the framework.

As PVOs, their counterparts, and ministries of health begin to use the HH/C IMCI framework as a tool for HH/C IMCI planning and implementation, best practices and state-of-the art information will be required to help guide the process and decision-making around various alternatives. Short implementation guides with tools highlighting best practices in different settings, required resource costs, and options based on different settings would help promote quality implementation. It is proposed that these guides be developed for each of the elements and the multisectoral framework as reference materials that can be used during the development of detailed implementation plans for HH/C IMCI.

Financial and technical support for national level meetings and collaborative efforts among the ministry of health, the PVO community, and partner and donor organizations to plan, monitor and evaluate an expansion strategy for HH/C IMCI based on this framework.

PVOs are critical to the development and implementation of sustainable child health and nutrition efforts at the community level due to their experience in community-based work. Through increased collaboration—both within the PVO/NGO community at the national level and between the PVO / NGO community and the Ministry of Health around a common vision and plan—HH/C IMCI implementation can be expanded. Resources to develop a forum to systematize PVO participation in HH/C IMCI and foster collaboration and sharing with the MOH at the national level are crucial. The framework can be used as one tool to help establish a common vision, define common targets and process indicators, clarify roles of implementers, and establish key strategies for implementation, monitoring, and sharing of lessons learned in HH/C IMCI. In many countries, PVOs and the

MOH work in relative isolation and do not take advantage of the breadth and depth of each other's experiences to reach common goals. HH/C IMCI provides a platform for a common understanding that can be used to initiate discussion among these groups and help them reach a common understanding.

Financial resources to increase service delivery of HH/C IMCI child health and nutrition activities, and multi-channel communication and behavioral change strategies

Once a common vision for HH/C IMCI is established and roles are clarified, funding is needed to expand implementation of HH/C IMCI based on this framework to a) increase use of facilities, b) increase quality of community-based care, and c) improve essential family practices for child health. As common tools are developed, adapted, and used by a critical mass of multiple implementers, the cost/benefits of HH/C IMCI implementation should decrease. Especially as decentralization and health sector reform takes place, successful cost effective strategies can gradually be built into district plans. Without additional resources to support HH/C IMCI implementation, it is unlikely that goals for the reduction of child morbidity and mortality can be met.

Financial resources for inter-country and inter-regional sharing, documentation, and monitoring of lessons learned.

The CORE Group demonstrates the valuable, cost-effective contribution it can make to child health through collaboration of its members. Because of the decentralized nature of many PVOs, coordination between countries and even within organizations is not optimal. Resources to support the documentation of PVO efforts, and successful national coordination activities are critical to enable new countries and new PVOs to incorporate these tools and lessons learned.

1.0 Introduction to the Conference

Over 130 representatives from more than 40 private voluntary organizations and colleague agencies met in Baltimore on January 17-19, 2001 for a three-day workshop, “Advancing PVO/NGO Technical Capacity and Leadership for Household and Community Integrated Management of Childhood Illness (HH/C IMCI).”

The workshop, convened by the Child Survival Collaborations and Resources (CORE) Group¹ with support from BASICS II, brought together key donors, colleagues and PVOs to articulate their common vision for the future of HH/C IMCI and share their field experiences from Asia, Africa, and Latin America. PVOs were invited to move forward aggressively with the implementation of Household and Community Integrated Management of Childhood Illness (HH/C IMCI). The workshop was preceded by *IMCI 101*, a one-day overview of the basic principles of IMCI, hosted by the Child Survival Technical Support Project (overview in Section 12.3).

1.1 Goals and Desired Outcomes of the Workshop

Goal:

To enhance the capacity of CORE PVOs to take greater leadership in the development and implementation of national and district HH/C IMCI programs.

Outcomes:

- A clear understanding of the PVO/NGO role in the development and implementation of HH/C IMCI Programs
- An increased understanding and application of lessons learned, better practices, and approaches that can be used in HH/C IMCI programming
- An increased understanding of processes that will enhance PVO/NGO leadership roles in HH/C IMCI at national, district, and community levels

- A unifying framework for HH/C IMCI programming

Community IMCI is a national process, focused on the district level, implemented through partnerships with communities, building on existing organizations, programs, experiences, and assets, to promote a set of key behaviors that improve the health and nutrition of young children.

-Vincent Orinda, UNICEF

1.2 Background: Recognizing Community-Based Approaches to Child Health

UNICEF’s *State of the World’s Children Report 2000* highlights the disproportionately high childhood mortality of the world’s poorest countries. Though mortality rate of children under five years of age has declined world-wide since the advent of primary health care, the under-five mortality rate in over 50 countries remains greater than 100 deaths per 1000 live births.

In twelve of the poorest countries, one in five children die before their fifth birthday. The vast majority of these deaths can be attributed to pneumonia, malaria, measles, diarrhea, and malnutrition. (Claeson and Waldman, p.1234)

The World Health Organization (WHO) and UNICEF launched the Integrated Management of Childhood Illness (IMCI) in 1992 as a strategy to combat these important causes of illness and death in an integrated ‘whole child’ approach. IMCI is intended to supplant more vertical programs with integrated and

¹THE CORE Group was established in 1997, with financial support from USAID. It is composed of 35 international NGOs who have been awarded USAID Child Survival Grants.

manageable packages of services for prevention of illness and promotion of health.

Its three components are:

1. Improvements in health worker skills
2. Improvements in health systems (to ensure availability of drugs and supplies)
3. Improvements in family and community health practices

Early efforts and allocation of resources focused heavily on the first two components of IMCI. However, there is a growing understanding of the community's contribution to improving and sustaining health initiatives. Training health workers and improving health systems alone will not reduce child mortality. The third component, community IMCI, is now recognized as a highly effective strategy to significantly reduce child morbidity and under-five mortality. At the same time, community IMCI creates a groundswell of community involvement and commitment to sustain initiatives long after outside funding has ceased.

A number of international workshops and the ongoing work of the Inter-Agency Working Group (IAWG) for IMCI have called further attention to the importance of household and community IMCI (HHC IMCI), and have contributed to a better understanding of the role of PVOs in this effort.

1.3 Evolution of the Role of PVOs in HH/C IMCI

April 1997: Formation of CORE Working Group on IMCI

September 1997: First Global IMCI Review and Coordination Meeting (Dominican Republic)

Acknowledged the importance of HH/C IMCI and recognized the role of families and communities in improving child health.

October 1997: UNICEF meetings with PVO participation (New York)

Produced a mandate for working at community level simultaneous to work at the policy level.

February 1998: IAWG established to develop guidelines for HH/C IMCI with UNICEF leadership

CORE Group participation included.

February 1999: Reaching Communities for Child Health: Partnering with PVOs in IMCI (Washington, D.C.).

CORE met at the Pan American Health Organization where PVOs and global partners acknowledged the role of PVOs in advancing HH/C IMCI and established steps for collaboration.

June 2000: Africa International Workshop in Improving Children's Health and Nutrition in Communities (Durban, South Africa).

Consensus reached on set of 16 key family practices. Delegates acknowledged the role of HH/C IMCI in improving these practices and the potential for taking child survival programs to scale. Stakeholders called upon to support and implement HH/C IMCI. CORE PVO programs featured as "models."

January 2001: Advancing PVO/NGO Technical Capacity and Leadership for HH/C IMCI (Baltimore, Maryland).

PVOs and other partners reach consensus on an operational framework for HH/C IMCI. Partners called to formulate implementation strategies and provide leadership for global action.

Today's vision for community IMCI is founded on vast PVO/NGO experience and leadership in working with communities. PVOs have contributed significant financial and in-kind resources to community health activities, and have developed a sizable toolbox for this work. As a member of the IAWG on IMCI,

CORE continues to represent the experience and interests of PVOs in IMCI tool development, training needs, advocacy strategies, and the establishment of an operations research agenda to document successes and lessons learned. PVOs continue to forge collaborative alliances both among themselves and with multilateral agencies, cooperating agencies, and funding agencies to advance the agenda of HH/C IMCI.

1.4 Developing a Framework for Universal Understanding and Promotion of HH/C IMCI

The driving force of the workshop, and one of its most promising outcomes, was the development of a dynamic framework for community IMCI. The need for such a framework arose out of concern about ineffective communication regarding the third component of IMCI—improvements in family and community health practices. Whereas there is general agreement on the first two components of IMCI—improving health worker skills and improvements to the health system—a clear consensus on what constitutes community IMCI has remained elusive.

The 1999 meeting at the Pan American Health Organization (PAHO) in Washington, DC produced a heightened awareness of HH/C IMCI among PVOs. A clear standard for working with communities and the health systems that serve them is important. This will be especially true as PVOs seek to communicate lessons learned, scale up successful activities, and advocate with funding agencies and policymakers.

The need for a standard led to the development and testing of a proposed ‘tool’ that would characterize the full scope of intervention options for HH/C IMCI. The effort began as a technical report on HH/C IMCI by the Child Survival Technical Support Project (CSTS), Johns Hopkins University and BASICS II. The initial product was circulated for review by PVOs, the CORE Group, IAWG members, and USAID’s Bureau for Humanitarian Response/ Office

of Private Voluntary Cooperation (BHR/PVC), resulting in over twenty revisions.

The tool provided the organizing outline for this workshop. The agenda was designed such that each piece of the tool or key issue constituted a panel. In each panel, presentations from field projects offered examples of the intervention or activity under discussion. The moderator of each panel provided a larger context for the issue. General discussion during each panel yielded many thoughtful insights. Small working groups discussed issues and developed specific recommendations.

Workshop organizers charged participants with the task of working towards a consensus framework for HH/C IMCI that would maintain the flexibility necessary in the face of the unique situation presented by each country and district, without limiting the innovations that are the cornerstone of NGO successes. Presentations by PVO representatives provided a sampling of the exciting and encouraging work PVO/NGOs are currently engaged in and how they fit into the HH/C IMCI framework for action. Their presentations are highlighted in the chapters that follow; the full text of most country presentations can be found in the Appendices.

For HH/C IMCI we need a set of technical guidelines and principles for working together in which all parties learn from one another to guide the work...we must return home with a clear agenda of what we need to do to advance IMCI implementation in our countries and with our many partners.

-Larry Casazza, World Vision; CORE IMCI Working Group Co-chair

2.0 HH/C IMCI Framework

The participants brought the full force of their experience to the task of refining HH/C IMCI into a model that could be readily explained to colleagues, government counterparts, and donors. All partners would need consensus for planning and implementing sustainable programs for child and family health. What evolved from these discussions was a framework for HH/C IMCI that provides everyone with clear direction for assessing programs, planning future programs, and advocating for necessary resources. Using this framework, all partners, including donors, can determine where the work is on track and develop realistic strategies to fill any gaps.

A multisectoral platform (MSP) forms the base of the framework. Its location at the base acknowledges that many sectors influence and contribute to a community's health, including water and sanitation, education, income generation, food production, and local government. In order to achieve sustained improvements in health, it is critical to support the community's involvement and give the community the freedom to identify and work for its own priority needs.

The framework describes three elements of HH/C IMCI. These elements recognize the many influences on a family's health promotion and health care-seeking behavior. Element 1 seeks to build partnerships between health facilities and communities. Element 2 addresses the need to assure appropriate and accessible care and information outside the formal health sector (from community-based providers). Element 3 targets communications with families and communities to promote key family practices critical for child health and nutrition.

2.1 Options versus Elements

The workshop participants deliberately changed the wording in the original proposal to reflect "requisite elements" instead of "options." In doing so, they clearly established the notion that a full HH/C IMCI program should strive to work with all sectors that impact a community's health. All elements are integral to HH/C IMCI and should be incorporated to the extent with which they exist in the community.

In fully operational community IMCI, all elements are strongly linked together. For example, as families

adopt improved home health behaviors, including recognition of danger signs (Element #3), they will seek care from outside providers or health facilities (Elements #1 or #2). IMCI-trained health facility workers may rely on drug sellers or traditional birth attendants for referral of more serious cases (Elements #1 and #2). Presentations during the workshop illuminated the linkages already found between elements.

The framework offers flexibility as to whether elements are programmed simultaneously or are phased in over time. Many successful community-based programs have not achieved the full application as defined by this framework. Workshop participants discussed strategies for bringing existing programs up to the full scale described through this framework, and shared promising examples.

Whether striving for closer community links with health facilities (Element #1), involvement of private or traditional providers in quality IMCI (Element #2), or better household practices regarding child health (Element #3), there are several issues that cut across all of these elements. These cross-cutting issues determine the extent to which initiatives will be embraced by the community and the magnitude of the impact over the long term for the larger country program. The issues of community mobilization, sustainability and building partnerships to scale up are not new to PVOs. These issues are highlighted in Section 7 with examples of how PVOs are addressing them around the world.

Community IMCI is the optimization of a multi-sectoral platform for child health and nutrition that includes three linked requisite elements:

1. Improving partnerships between health facilities and communities
2. Increasing appropriate, accessible care and information from community health providers
3. Integrated promotion of key family practices critical for child health and nutrition

HOUSEHOLD & COMMUNITY IMCI

AN IMPLEMENTATION FRAMEWORK

ELEMENT 1

Improving partnerships between health facilities and the communities they serve



ELEMENT 2

Increasing appropriate and accessible health care and information from community-based providers



ELEMENT 3

Integrating promotion of key family practices critical for child health & nutrition



MULTI-SECTORAL PLATFORM

Optimizing a multi-sectoral platform to support sustainable child health & nutrition

2.2 Principles of HH/C IMCI

Workshop participants addressed a number of questions relevant to the adoption of an operational framework for their work with HH/C IMCI:

■ **The timing of community IMCI interventions:** Can PVOs implement IMCI before there is a national strategy? Can community IMCI be implemented before health facility staff are trained?

■ **The introduction of the elements of HH/C IMCI:** Are interventions that solely address prevention without connections to health facilities or curative care providers suf-

ficient to be considered community IMCI? Does one agency have to implement all three elements? Is it necessary to develop interventions that address all three proposed elements at the same time?

■ **The focus of HH/C IMCI interventions:** Is community IMCI focused only on the ill child or on the healthy child as well? Is it necessary to promote all the key family practices at the same time?

In response to these questions, participants put forth a set of guiding principles for their work with household and community IMCI.

PRINCIPLES OF HH/C IMCI

HH/C IMCI can be implemented at national, district and/or community levels, as appropriate

A locally implemented HH/C IMCI program should ideally be linked to a national plan.

HH/C IMCI can be implemented by multiple actors or by a single organization.

The framework is based on the premise of partnerships.

HH/C IMCI recognizes the importance of curative and preventive interventions in the community for reducing child mortality and morbidity All aspects of a child's health and well being are important.

HH/C IMCI can be implemented with or without IMCI Components 1 (health worker skills) and 2 (health systems support) The presence or absence of work with the other components of IMCI should not limit the ability of PVOs to test and implement HH/C IMCI, but ultimately the vision is for all three components to be functioning together.

All three Elements are requisite for HH/C IMCI (except Element #1 if facilities are inaccessible) The framework should not be limiting, but all elements should be pursued wherever possible.

Phased introduction of promotion of key family practices is acceptable It is important not to overwhelm families and communities by introducing too much at once, but a good HH/C IMCI plan should include the eventual phasing in of all practices.

Phased introduction of the three elements is acceptable Planning should take into account community priorities and services, eventually including all elements of the framework.

3.0 Multisectoral Platform

The multisectoral platform (MSP) at the base of the HH/C IMCI framework is fundamental to sustained work in health. Similar to comprehensive primary health care, the MSP recognizes that many factors contribute to the health and well being of children and their families. Alleviating illiteracy and poverty, providing clean water, and generating income for food and medicines may all contribute in substantial ways to a community's ability to assure and sustain its health. Global leaders in health increasingly are looking to multiple entry points for working with communities. Development partners must boldly address the many influences on child health and development, including education and gender equity, psychosocial care and development, issues of protection and care, and maternal health. UNICEF's Early Childhood Development Framework proposes a role for non-health sectors in addressing poverty and other factors affecting early childhood development.

PVOs excel in integrating health with other sectors and using work in other sectors to support health. Because they frequently carry out projects in other sectors, PVOs often have expertise in agriculture, water and sanitation, education, and so on. Programs that build on existing community-based efforts and address community priorities lead to empowered communities and sustainable health programs. By acknowledging the broader interests of the community, PVOs

HH/C-IMCI is an entry point for many sectors to work with families at the household and community level to improve care of infants and young children. The Convention on the Rights of the Child contains articles conveying a moral and ethical basis for many sectors of government to invest in young children.

-Vincent Orinda, UNICEF

address factors that facilitate or hinder the adoption of new practices and behaviors that are promoted through HH/C IMCI. For example, programs that improve water and sanitation may be successfully linked to the promotion of handwashing; income-generating activities can be linked to bednet purchase and use. An example of this connection is Freedom from Hunger's use of credit and savings networks coupled with health education to enable very poor women to overcome chronic hunger and malnutrition for themselves and their families (*Section 8*).

With a national consensus on a framework for action in HH/C IMCI, resources from many sectors and diverse geographic regions can be mobilized around common goals or a common approach to extend the benefits of HH/C IMCI to all parts of a country.

Key competencies of PVOs for implementing the multisectoral platform

- **Work with non-health groups that connect with communities for change (schools, religious groups, financial sector, agriculture and sanitation); PVOs have a large and diverse in-house skill base because they work with many sectors.**
- **Flexibility to coordinate among all stakeholders (government and non-government) in various sectors.**
- **Proven ability to mobilize communities and advocate for communities according to their own priorities.**
- **Access to resources that are attractive to all sectors.**
- **Capacity-building expertise in planning linked to civil structure (i.e., local district planning authority).**

4.0 Element #1:

Partnerships between Health Facilities and the Communities they Serve

Many countries have begun to implement IMCI by improving the formal health system. Training programs that orient health workers to IMCI, the decentralization of health services, and the Bamako Initiative in Africa are important contributions to improving access to quality health services. However, these approaches can only result in improved health if the community uses the services. Frequently, however, utilization of services remains low due to frustrations between communities and health facility staff. Community health workers trained in IMCI may receive inadequate support from the community or from distant health facility staff to sustain quality service delivery.

The approach in Element 1 is to build a two-way partnership between facilities and communities. In general, Element 1 emphasizes improving outreach and interpersonal counseling skills among health providers, and makes providers more accountable to communities for the quality of health services. It addresses the community's responsibilities as well, emphasizing

community awareness of improvements to health services as well as the appropriate, timely use of health services. Activities to foster community management of health services are also part of Element 1. Communities may contribute to community-based health information systems, and work with trained facility-based staff to use this information in planning, implementing initiatives, and monitoring service quality.

PVOs bring important expertise to the design and implementation of programs linking communities and health facilities. They have established long-term, trusting relationships with communities and have developed a number of important tools for this work. PVOs that hold the respect of both the community and health facility staff can help to build mutual trust and bridge socio-economic and cultural gaps between the two.

In addition to tools and strategies developed by PVOs, PAHO (together with the CORE Group, NGOs, and ministries of health) developed a number of important tools for use with Element 1. These include the IMCI training course for community health work-

Key competencies of PVOs for the implementation of Element #1

- Experience with quality improvement processes with community involvement (e.g., customer appraisal through exit interviews; Partnership Defined Quality).
- Elaboration of community-based surveillance and monitoring systems that facilitate community feedback on quality.
- Empowerment of marginalized groups (e.g., women, illiterate populations), and with non-health organizations; long-term relationships of trust with these groups and with communities in general.
- Mechanisms for community participation in management of health centers.
- Development of culturally appropriate messages to generate demand for services; training to improve outreach skills of facility-based workers.

ers; the “Talking with Mothers” module; and the Community Health Workers Profile and Training Process, an inventory for linking NGO work and resources with the Ministry of Health. A course for organizing IMCI at district level is in progress, as are various print and video materials based on the 16 key family practices. A new Latin American/Caribbean (LAC) initiative between PAHO and the American Red Cross will strengthen HH/C IMCI efforts in ten LAC countries.

4.1 Results from the Field

Catholic Relief Services (CRS)/Cambodia

The government of Cambodia established the 1996 National Health Coverage Plan with the goal of increasing community contributions for health services and community participation in the management of these services. The national plan gave NGOs a lead role in organizing community involvement. CRS responded with the Community-Based Primary Health Care Program. This model program aimed to increase both health facility utilization and service quality through a two-pronged strategy:

1. Involving the community in disease prevention and health promotion
2. Strengthening the health center

In keeping with government directives, co-management and co-financing of health facilities tightly linked the community and health facility to ensure long-term sustainability.

The project resulted in sustained increases in a number of health facility utilization indicators—antenatal care, new outpatient cases, average total cases—and in increased average monthly income from fees. As CRS financial support to health center operations was eliminated, the center moved closer to financial self-sufficiency. With increased community involvement, quality of service indicators also showed steady improvements.

Factors that contributed to the project's success

There were several factors that contributed to the project's success:

- The clear definition of roles and broad transparent participation of the community.
- Full government support (MOH, Provincial, district) for community role in health facility management and quality oversight.
- The use of existing community health workers to keep the community informed about processes.
- Health center and community contract to clearly establish roles and responsibilities of co-management and co-financing committee and health center.
- Equal representation of community and health facility on CMCF committee which included orientation and capacity-building for all members (topics included the health system, role of community feedback, and management).
- Strong community involvement in setting fees and exemptions (in accordance with community ability to pay).

CARE/India

CARE/India recognized the need for skilled health workers in the community to assure counseling and care for the most vulnerable population. Working in partnership with the Ministries of Health, Family Welfare and Human Resource Development, and the National Training Institute, CARE developed a team training approach to train community-based health workers, thus increasing demand for and use of essential care services. To assure technical support from the health facility, the project trained facility workers jointly with the community-based health workers.

The simple, integrated skill-based training provided community-based workers with the skills to assure early

care for sick children, and built in a critical link to health facilities for supervision and referral. An additional day of training for health facility workers in supervisory techniques and expectations helped assure follow-on support for the CHWs.

Factors that contributed to the project's success

There were several factors that contributed to the project's success:

- Clear objectives at outset with participation of all partners (Government of India, WHO, CARE and a local NGO) in program planning/priority setting, implementation, and follow-on advocacy
- Team training approach training those who are the first point of contact and their supervisors with training materials designed to reflect the educational level of the community-based worker
- Equal weight in training given to technical interventions and interpersonal communication
- Supervision built into training; scheduled follow-up supervision after 4-6 weeks
- Training in natural work environment where community sites provided an abundance of cases for hands-on practice and were more highly valued by trainees than the hospital-based practice sites
- Set of materials to support training of CHWs including learner's guide for CHWs, trainer's manual for the facilitators, colored clinical photograph booklet, video illustrating key danger signs, job aids for CHWs, mother's cards, monitoring tools, and supervisory tools for follow-up visits.

4.2 Challenges to Implementing Element #1

There are several challenges in addressing Element #1:

- Government-imposed transfers are a perennial issue for any program involving government health workers. Health ministries need to assess their transfer policies to provide greater continuity. PVOs might negotiate this when planning a HH/C IMCI intervention.
- For a program such as CARE/India's, with a high trainer to health worker ratio, the cost to cover a larger area can be prohibitive. Integrating such initiatives into professional (pre-service) training curricula can help reduce costs and assure greater sustainability.
- The government policy environment may pose the greatest challenge to broad application of this approach. If CHW training focused on referral precedes the introduction of IMCI at government health facilities, building meaningful linkages with health facilities can be difficult.
- PVOs need more opportunities to share their experiences, both through documentation and workshops. Advocacy at the national level on the basis of documented experience can help improve government understanding of PVO/NGO contributions to Element 1.

5.0 Element #2: Appropriate and Accessible Care and Information from Community-Based Providers

IMCI programs that target only formal health facilities fail to reach a significant proportion of the population. Many communities have little or no access to public health facilities. Long distances and difficult terrain may separate people from health facilities, particularly during rainy seasons. For these and a variety of other reasons, the first (perhaps the only) point of contact for health information and treatment is often a community-based provider. Community-based providers include those in the formal and informal private sectors: volunteer community health workers (CHWs), private providers, traditional healers, traditional birth attendants, shopkeepers, drug vendors, and pharmacists. It is important to identify the providers from whom care is sought, and to identify current practices.

Element 2 of the HH/C IMCI framework acknowledges the importance of care provided outside of public health facilities. Initiatives may seek to upgrade skills of community-based providers, assure care in line with the goals of IMCI and decrease harmful practices. In light of their trusting relationships with

the community, traditional community-based providers may be encouraged to expand their roles to encompass health promotion and preventive health.

Programs in Element 2 work to improve referral of sick children by community-based providers to the first-level health facility. They also seek to improve the flow of information between these distinct levels of care. Work with community health volunteers has been the backbone of many PVO programs. This approach may provide a cost-effective means to expand community health services. As one example, the ENLACE Project with CARE in Peru (Section 7.4) set up joint supervision of community health promoters by the promoters' association and health facility workers. This process produced a greater sense of joint ownership and a better mutual understanding of the project's goals. In so doing, the program enhanced the referral system and built confidence for counter-referrals, with each party demonstrating confidence in the other's ability to provide care and understand their respective limits.

Key competencies of PVOs for implementing Element #2

- Identification of current care-seeking behaviors (tools such as verbal/social autopsy, exit interviews, observations, provider interviews).
- Ability to negotiate government support of a clear role for private and traditional providers and to assure MOH participation in training, supervision, and referrals.
- Extensive experience with selection, training, and supervision of CHWs to serve as a key link between the community and the formal health system.
- Ability to test 'pilot' innovative approaches to help inform government policy for recognizing and incorporating community-based providers.

5.1 Results from the Field

CARE/Kenya

CARE/Kenya's Community Initiatives for Child Survival in Siaya Project (CICSS) increased community involvement in health decision-making and management while establishing improved access to care through community pharmacies and trained community health workers. The project's goal was to reduce child mortality through early community recognition and care seeking for common childhood illnesses, and through increased access to quality health services. In this case, increased access to care required the addition of providers outside the formal health system. In addition to the use of CHWs to increase access, the model strategy included the development of community pharmacies, links with the Ministry of Health at the district level, and strong community involvement. The project resulted in marked increases in vaccination rates through community-driven mobile immunization clinics. Focus group interviews with community leaders and individuals indicated a general sentiment that the 49 percent reduction in reported child deaths over two years is attributable to the project's integrated approach.

Factors that contributed to the project's success

There were several factors that contributed to the project's success:

- Community health workers increased access to quality health care and counseling. Selected by the village health committee (VHC), they were trained in project and financial management as well as curative and preventive services. IMCI training materials were adapted for the CHWs.
- Bamako Initiative model community pharmacies increased access to essential drugs and mosquito nets.
- MOH/district-level support for quality training and supportive supervision of CHWs, referral and project monitoring, and oversight of CHW drug kits. (The Director Of Medi-

cal Services approved administration of Fansidar and Cotrimoxazole by CHWs, with government health staff supervision).

- Community mobilization for health with representative village health committees. VHCs determined cost-sharing payment schedules and waivers and used CHW-generated health data for decision-making.
- Health education through local women's groups.

Minnesota International Health Volunteers (MIHV)/Uganda

In an isolated region of Uganda with a severe shortage of trained providers and poor access to health services, MIHV recruited and trained traditional healers and drug vendors to increase quality health services to the community. Baseline surveys indicated that virtually all children with presumed malaria received first treatment outside the public health system and the traditional providers are highly respected and widely consulted.

The project carefully selected participants who had the greatest influence in the community, were eager to increase their skills, and were committed to implementing approved practices to attend training sessions. Involvement of the district health team in their training resulted in improved relations and contributed to a unified vision for health in the community. By increasing timely recognition and referral of serious cases, this activity also resulted in improved use of health facilities. The community-based providers adopted improved skills in keeping with district health norms and gradually took on expanded roles in other health promotion activities (e.g., mobilization of popular support for malaria awareness days, micronutrient days and national immunization days). As these providers became more knowledgeable and passed their knowledge along, caretaker knowledge of danger signs and home treatment for malaria and diarrhea also improved.

Factors that contributed to the project's success

There were several factors that contributed to the project's success:

- Identification of frequently consulted providers (respected, easily accessible, sought for advice and treatment). Though these providers had limited formal education, they were enthusiastic students.
- Clear presentation of roles/responsibilities for the project, community, providers, and health facility.
- Training with adapted materials. Materials were kept simple but provided adequate and appropriate information for disease recognition and referral.

Traditional healers do not necessarily view child survival projects as 'competition'. Treated respectfully, they can bring much enthusiasm, knowledge, client access, and credibility to a project.
- Jolene Mullins, MIHV

- Health facility staff participation in selection, training, and supervision of private providers built collaborative relationship.
- Expanded role of traditional healers and drug vendors to encompass community mobilization/health promotion

5.2 Challenges to Implementing Element # 2

There are several challenges to addressing Element #2:

- There is a need to identify from whom the community seeks care and why before targeting a group of providers for an intervention in Element 2.

■ Attrition of volunteer community health workers has long plagued programmers. The relative advantages of pay and other incentives to improve retention need to be carefully researched and documented. Similarly, providers not bound by practice quality care and to promote key behaviors according to IMCI guidelines.

■ Working with private providers offers an opportunity to bring quality care to the community through those most often consulted in case of illness. However, this may raise policy issues for governments reluctant to legitimize practitioners or drug-sellers that work clandestinely. Both the Kenya and Uganda projects demonstrate the importance of obtaining MOH support for the initiative. In both projects, the PVOs also obtained the commitment of district medical personnel to assure technical supervision. Working in partnership with the MOH, skills can be upgraded in keeping with IMCI guidelines, treatments that are widely available (whether legally or not) may be more appropriately used, and allies are created for adequate and timely referral to health units.

■ Before deciding to train and utilize CHWs to improve access to quality care, programmers need to carefully consider whether people will consult CHWs. This includes considering what inputs may be needed to make the CHWs most successful and sustainable as a community health resource.

■ Those programs that pilot distribution of essential drugs by CHWs need to develop a program that addresses three key issues:

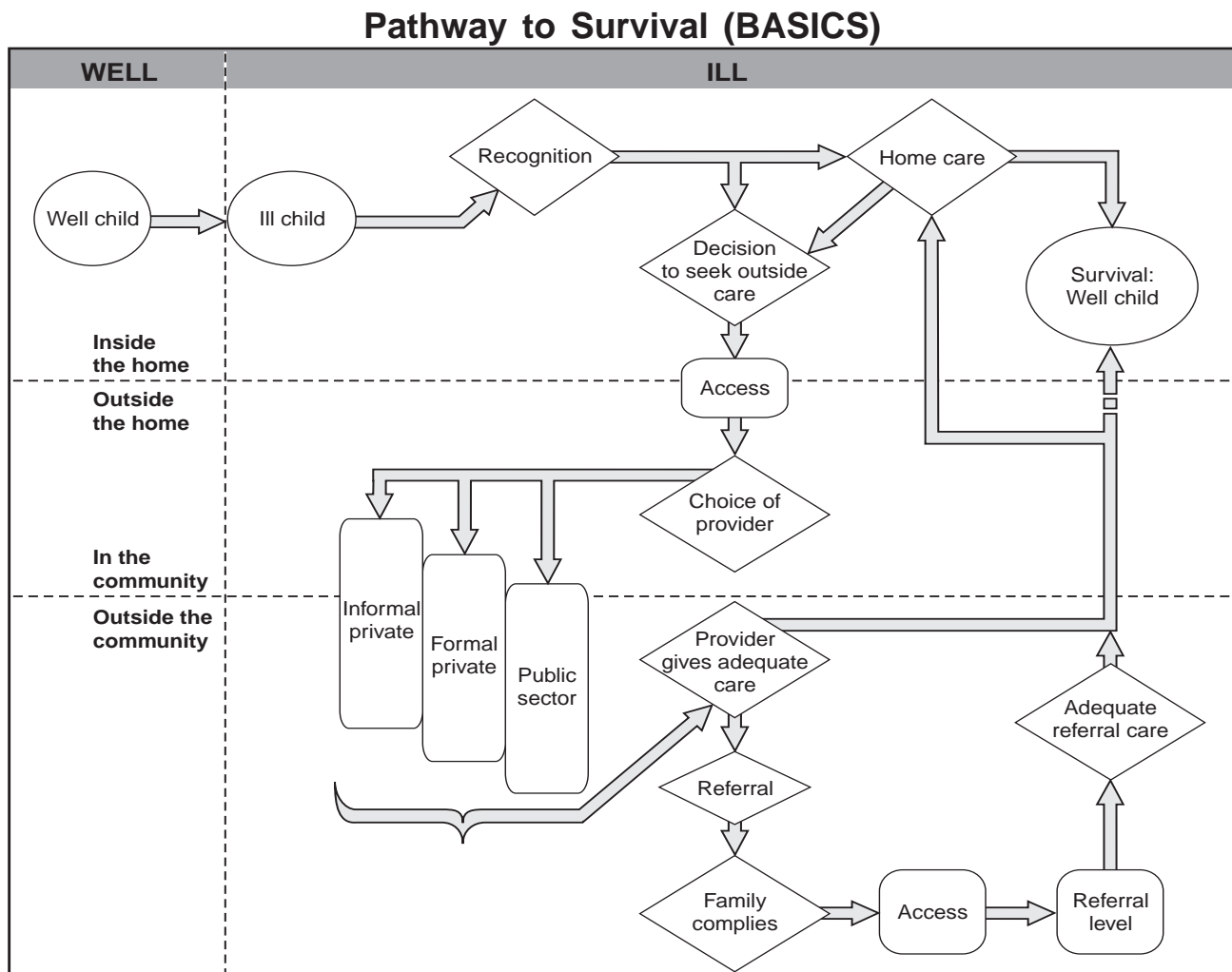
- Health worker training & retraining;
- Systems support (supervision, drug logistics, quality control); and
- Household and community participation in supporting this approach..

6.0 Element #3: Integrated Promotion of Key Family Practices Critical for Child Health and Nutrition

The activities in Element 3 go to the heart of families' desire for the good care and long-term health of their children. The treatment of a sick child usually begins in the home. In fact, caretakers in the home make many decisions that directly impact the overall health and well being of the child, including vaccinations and early child nutrition. Recognizing this, the primary focus of activities in Element 3 is on sustainable behavior change by families.

Successful HH/C IMCI influences key family

behaviors all along the continuum of child health, from behaviors that promote wellness to care seeking during illness. A number of important tools elucidate for programmers and planners the many points of influence along this continuum. The Pathway to Survival (shown below) is a tool developed by BASICS in collaboration with USAID and the Centers for Disease Control and Prevention (CDC). It helps distinguish behaviors that are carried out entirely in the home and those that require the support of health providers.



This pathway illustrates how a program that emphasizes improvements only with health facility staff or health providers will miss many important opportunities. The pathway has proved critical for communications specialists in designing programs for behavioral change that address all points of influence on child health and illness.

On the basis of this and other models, UNICEF, in collaboration with the IAWG, developed a list of 16 key family practices for IMCI. These practices are behaviors that have a proven impact on the health and well being of young children. The key family practices are grouped into four categories:

1. Those that promote physical growth and development
2. Those that prevent disease
3. Those that facilitate appropriate home care
4. Those that facilitate care-seeking behaviors.

Activities in Element 3 seek to promote an integrated package of behaviors that correlate with IMCI

implementation at facilities and with other providers. Initially, some behaviors may be emphasized over others in accordance with expressed community needs and priorities.

There has been a wellspring in the Communication for Behavior Change community of rapid, easily used tools for behavioral analysis and behavior change. Such tools include for instance, verbal and social autopsies, positive deviance inquiry, and participatory community assessment and planning. These tools isolate the implications of care inside and outside the home to facilitate decision-making on priority target behaviors and translate those decisions into concrete plans of action, thereby engaging stakeholders and partners in a shared mission. In Honduras, an integrated Communication for Behavior Change package has become the focal point of a national program in which advocacy and social mobilization complement traditional multi-channel interventions including mass media, community education and provider Freedom from Hunger

The Freedom from Hunger Credit with Education Program offers an innovative example of a

Key competencies of PVOs for implementing

- **Long-term trusting relationships at all levels, from national government to community level.**
- **Collaboration in the Communication for Behavior Change community with multiple sectors, in an integrated 'person-first', holistic manner.**
- **Common vision for child health, provides foundation for partnerships and networks in communications (PVOs share vast tool-box for training materials design, research methods, monitoring, supervision, and evaluation).**
- **Grass-roots commitment is fundamental to PVO work.**
- **Ability to organize communities (i.e., mothers groups, CHWs, village health committees, village development committees) to enhance needed skills and rally their commitment to change; tools for bringing communities into the problem-solving process (e.g., Positive Deviance, Community Action Cycle, Participatory Learning and Action).**
- **Expertise in designing and implementing entry strategies for community mobilization and development.**

Sixteen Key Family Practices for IMCI

(Presented at the International Workshop on Improving Children's Health and Nutrition in Communities, Durban, South Africa June 20-23, 2000)

For physical growth and mental development

- Breastfeed infants exclusively for at least four months and, if possible, up to six months. (Mothers found to be HIV positive require counseling about possible alternatives to breastfeeding.)
- Starting at about six months of age, feed children freshly prepared energy and nutrient-rich complementary foods, while continuing to breastfeed up to two years or longer.
- Ensure that children receive adequate amounts of micronutrients (Vitamin A and iron, in particular), either in their diet or through supplementation.
- Promote mental and social development by responding to a child's needs for care, through talking, playing, and providing a stimulating environment.

For disease prevention

- Take children as scheduled to complete a full course of immunizations (BCG, DPT, OPV, and measles) before their first birthday.
- Dispose of feces, including children's feces, safely; and wash hands after defecation, before preparing meals, and before feeding children.
- Protect children in malaria-endemic areas, by ensuring that they sleep under insecticide-treated bednets.
- Adopt and sustain appropriate behavior regarding prevention and care for HIV/AIDS affected people, including orphans.

For appropriate home care

- Continue to feed and offer more fluids, including breastmilk, to children when they are sick.
- Give sick children appropriate home treatment for infections.
- Take appropriate actions to prevent and manage child injuries and accidents.
- Prevent child abuse and neglect, and take appropriate action when it has occurred.
- Ensure that men actively participate in providing childcare and are involved in the reproductive health of the family.

For seeking care

- Recognize when sick children need treatment outside the home and seek care from appropriate providers.
- Follow the health worker's advice about treatment, follow-up and referral.
- Ensure that every pregnant woman has adequate antenatal care. This includes having at least four antenatal visits with an appropriate health care provider and receiving the recommended doses of the tetanus toxoid vaccination. The mother also needs support from her family and community in seeking care at the time of delivery and during the postpartum and lactation period.

multisectoral approach to health. Its long-term goal is increased food security and improved health, especially for children.

The approach is three-pronged:

1. Credit (village banking) to address poverty through income-generation and personal savings
2. Women's groups (village banks) that foster peer assistance with health and credit issues
3. Health education through weekly village bank meetings and nontraditional channels (village bank field agents)-caregiver counseling.

6.1 Results from the Field

Project Concern International (PCI)/Nicaragua

To improve health services in marginal urban neighborhoods, PCI/Nicaragua designed an educational model to assure sustainability of a community-project resulted in significant increases in the community's consultations with health staff and CHVs ("brigadistas") for growth monitoring and medical treatment. These increases can be largely attributed to links created between the community and health facility. Improvements were also noted in prevention and health promotion behaviors, such as exclusive breastfeeding, prenatal care, and vaccination rates. These health promotion behaviors were all subjects of health education messages communicated through the multiple sources tapped by this project. Building on its successes, the project scaled up in several ways: it expanded to rural areas, sent messages through radio and video, added work with midwives and development committees, and broadened its scope to work in agriculture and water in addition to health and education.

Factors that contributed to the project's success

The project employed a number of successful approaches:

- Multiple entry, integrated approach using participatory education as a key strategy; focus on numerous avenues of dissemination and

on the integration of messages (mothers, students, CHVs)

- Systematic methodology for working with CHVs (reviving an old network); CHVs first received training in integrated health messages, then were trained on individual health issues, one at a time

- Coordination at multiple levels (local, departmental, national) to facilitate follow-up and sustainability; encouraged the community to build links between CHVs and the MOH; planning included forewarning health facility staff and national planners that project activities would result in initial increase in demand for services, including community outreach

- Local use of locally generated health information to maintain community and CHV motivation (involving the community in situation analysis and ongoing target-setting, comparing community-based health information with health facility-generated data); use of Maternal Child Health Calendar enhanced CHV abilities in interpersonal communication

Save the Children/Vietnam

Save the Children's Poverty Alleviation and Nutrition Program (PANP) applied a Positive Deviance approach to involve target communities in the identification and adoption of successful feeding, caring and health-seeking behaviors. Positive Deviance Inquiry (PDI) was used to examine the key practices of families who had healthy well-nourished children, despite 'high-risk' conditions. The Positive Deviant families faced situations of poverty and other difficulties similar to the rest of the community. These positive practices were applied and shared with mothers in the community through a nutrition and rehabilitation program where caregivers practice new behaviors with their peers.

Follow-up evaluations demonstrated sustained improvements in the group's nutritional status and related sanitary practices. More significantly, these

improvements were even more dramatic among the participating children's younger siblings when compared to a control group, even though the siblings were not exposed to the program. These data reflect the sustainability of this approach. The Positive Deviance tool is being studied in other countries for behaviors as varied as immunization practices in Nigeria, pregnancy behaviors and birth outcomes in Upper Egypt, and correct condom use by commercial sex workers in Myanmar.

Factors that contributed to the project's success

There were several factors that contributed to the project's success:

- First-hand practice of Positive Deviant behaviors and observation of the beneficial results by mothers can motivate long-term behavior change
- Positive Deviance is a local solution where the community participates in the analysis and identification of the key practices from the PDI and in generating solutions thereby providing a community focus on the problem *and* the solution
- Careful monitoring and scientific documentation facilitates broad recognition of the approach "Living University" established to 'scale up' the approach to other geographic areas through the training of other organizations.

6.2 Challenges to Implementing Element #3

- Sustaining behavior change over time and scaling up successful local interventions are among the challenges faced by PVOs for the implementation of Element three. PVOs and donors need to develop and test new monitoring and evaluation tools for HH/C IMCI communications programs.
- There is a continuing need to improve the interpersonal communications skills of providers. Providers particularly need skills in demonstration techniques, verification of understanding, and negotiation.
- At the national level, programs like immunization and diarrheal disease control require technical expertise and leadership. They may be separate entities at this level. The challenge for PVOs and national level planners is to maintain a unified vision for integration of these programs at the community level.
- Another challenge is to better understand the effectiveness of the phasing in and integration of messages for the 16 Key Family Practices.

7.0 Cross-Cutting Issues

Several important issues cut across all technical interventions, whether a project is working to improve facility-community linkages, improve care by community-based providers, or promote key behaviors in the home. The cross-cutting issues of the HH/C IMCI framework are community mobilization, sustainability, and scaling up. These cross cutting activities constitute a strategy for mobilizing and maintaining support from the community, government and other partners for the interventions described earlier.

Community mobilization has challenged programmers in all development sectors. Successful community mobilization is key to long-term sustainability. The world has become more ‘global’, and there now exists a fairly widespread conviction that health is a universal right. With this as their vision, NGOs, donors and governments must grapple with how to scale up a successful intervention to benefit millions where it may now reach thousands.

Community mobilization for social change is a key competency of PVO's that needs to be documented more systematically.

-Karen LeBan, BASICS II

7.1 Community Mobilization

PVOs have long understood that the community must play a key role at every stage of an intervention in order to ensure its relevance to the community and sustain the achievements for lasting health. The community should help to continually refocus the work, from planning throughout implementation to monitoring and evaluation. Typically, communities mobilize around a palpable goal, like building a school, a clinic building, or a well. But increasingly, communities are coming to understand health problems as a rallying point. Successful HH/C IMCI projects demonstrate the potential for mobilizing long-term community commitment to improving the less-tangible foundations of good health (e.g., quality care, timely referral, and prevention).

Whether the intervention is aimed at health facility-community relations (Element 1), at providers outside the facility (Element 2), or at family/household behaviors (Element 3), it is critical that the community be full stakeholders. Community mobilization should be viewed on a continuum. It begins with creating a fuller understanding within the community of the goals for health programs. Understanding progresses to in-

If we can shift the way we invest in health to involve support to communities, then we will be supporting sustainable initiatives.

-Al Bartlett, USAID

creased participation. This leads to eventual full commitment, both mentally and socially, to creating a set of priorities and the means to achieve them. This commitment is the necessary platform for community ownership and long-term sustainability. Donors and governments need to understand that true community ownership will not be achieved overnight. However, a community's ability and willingness to identify problems, seek solutions and monitor the quality of services will assure that the benefits of a program extend beyond the initial period of investment.

7.2 Results from the field

Save the Children/Bolivia

Health service utilization in a rural community of Bolivia remained low despite new government initiatives to increase access (Law of Popular Participation and decentralization of health services). Save the Children designed the SECI project (System for Integrated Community Epidemiology) to increase health service utilization through community mobilization. The project built on long-held traditions of community participatory planning, commonly practiced by agrarian unions and taxpayers. This approach was rarely used by a health system in which information collected at the health facility typically served only government planners instead of communities. Through a process called the Community Action Cycle, the facility-based

information system was combined with a community-based and managed health information system, to provide the opportunity for the community to share information and responsibility for its health and local health services.

Volunteer health promoters (VHPs) worked with health system providers to collect and analyze data. They shared this information with the community in ways appropriate for an illiterate population, such as pictorial health indicators. This allowed for community input, joint planning, and ongoing monitoring by the community of improvements in health and health services. As the community took a greater leadership role in planning and implementation, they came to a new understanding of health problems and of their own role in developing solutions. The results were more favorable in communities where the facility information was shared with community members jointly by health staff

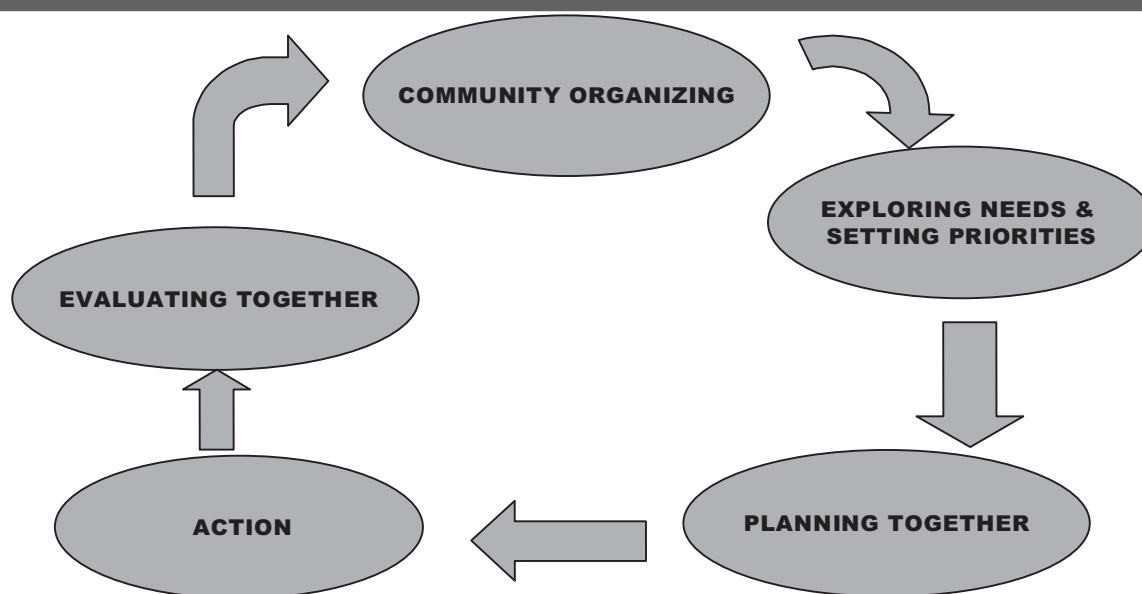
and VHPs than where the health staff did not attend community meetings. Sharing information jointly resulted in increased health facility utilization, better communication, and improved trust. Communities planned and implemented their own health promotion projects and formulated collective agreements to use health services. Vaccination coverage rates increased significantly as communities participated in planning and implementing immunization services.

Factors that contributed to the project's success

There were several factors that contributed to the project's success:

- Built on existing cultural foundations and in the context of supportive government policy
- Dialogue between communities, VHPs

“Community Action Cycle”



and health facility staff resulted in the redistribution of resources for mutual benefit (e.g., the community requested outreach visits, arranged emergency transport for referral, and discussed quality concerns with health staff)

- Community-based HIS improved community understanding of health system constraints; improved care-seeking behavior and early feeding practices

- Community role in planning and providing feedback led to improvements in service quality and service delivery

World Vision/Republic of South Africa

Health is a major building block of the Reconstruction and Development Program of the New South Africa. As in Bolivia, government reform efforts provided the authority for strong community participation. Unlike Bolivia, however, there existed little foundation in South Africa for strong community input at the start of this project. In six years of project implementation, World Vision was able to create a model that inspires community mobilization efforts throughout the region and the nation, using creative tools for mobilizing communities to action. Visitors to the region discover communities that are well aware of their role in the new South Africa's health plan and are eager to articulate their contributions.

Project communities achieved increases in vaccination coverage and in key home health and nutrition behaviors. Additionally, the referral network was strengthened. The project encouraged community involvement through a series of activities and processes:

- Visioning exercise at district level: World Vision was critical to providing a neutral ground for mobilizing fragmented pieces of government to discuss and articulate their common purpose; established guiding principles for working with the community in IMCI

- Participatory Learning and Action (PLA) exercises: integrated communities into the national health development process

- Quality Assurance Tools: quality assurance advisory and support team in regional office, measuring quality helped unify action on critical issues

- Transformational Leadership: a client (i.e., community)-centered business approach focusing on future goals and direction (vision) to guide current programming

- Knowledge, practice and coverage surveys: information for community involvement in program design and monitoring of impact

7.3 Sustainability

In the same way that community mobilization is an essential ingredient for the success of all elements of HH/C IMCI, the factors contributing to long-term sustainability of these initiatives must be carefully considered and planned. PVOs have grappled with issues of sustainability in general and with sustaining volunteer health workers specifically for years. One description of sustainability is that of a general phenomenon of program continuation through one of three ways: the initial program continues intact, the project's activities become institutionalized within a local organizational structure, or the activities continue through some community mechanism. The sustainability of an initiative might also be reflected in its ability to bear the weight of scaling up to a larger community, an entire region, or to a national scale, sustaining volunteer health workers in particular for years.

It is critical to plan and build into any program the capacity of the community to maintain its part of the project, and more importantly, its desire to continue the processes that allow the community to play the leadership role in priority-setting, implementation and ongoing monitoring of health programs. A program may be continued through the initial program approach or by its adoption into a local organizational structure. The HH/C IMCI initiatives most frequently described by PVOs have been sustained through the community's increased motivation and ability to continuously identify needs and seek out and implement local solutions.

Community Health Workers (CHWs), volunteers who are based in the community and are not directly financed by the health system, have been used in a variety of ways to increase sustainability. They may help refer patients to facilities, link facilities and communities through community-based HIS, or serve on health facility management committees (Element 1). They might diagnose and distribute basic medicines and oral rehydration salts (Element 2). They might work with communities to promote messages for key family practices (Element 3). The sustainability of community-based practitioner programs (the focal point of this cross cutting issue) might be described as a continuing system of recruitment, training, and supervision of a cadre of volunteers in a community or district that meets its members' or group health care needs. Sustaining the quality work of CHWs depends on built-in incentives and support from both the formal health system and the community. A community will appreciate CHWs' contributions more fully if the community has participated in the selection, training and

supervision of CHWs, or if it works with CHWs to use community-generated information for health programming. This may in turn engender a greater willingness to motivate and reward CHWs. Non-monetary incentives or rewards include elevated community status and respect, preferential treatment, and personal growth through acquisition of new skills. Health facility staff and district health staff can also motivate CHWs through supportive supervision and recognition (ex. attending community meetings with the CHW and making counter-referrals for follow-up). Staff may be encouraged to adopt health policies and plans that include a role for CHWs.

7.4 Results from the Field

CARE/Peru

The ENLACE project in rural Peru provides an example of sustainability achieved through the design of systems linking community health promoters (CHPs) with the health facilities. Activities included communication for behavior change (via interpersonal communication, contacts during community events, and local radio); training of health facility staff in clinical and management issues; training of all parties in referral and counter-referral; and a community-based health surveillance system. Using community-generated health information, CHPs and health facility staff jointly planned and implemented activities, with the concurrent involvement of the health committee. In addition, CARE worked with the Ministry of Health to establish and strengthen community health promoter associations (CHPAs) as a support network for the CHPs. The CHPAs provide formal representation of health promoters, aiding their collaborative work with the formal health system at the facility, district and municipality levels.

Initial evaluation of the pneumonia component of the project showed a dramatic increase in caretaker knowledge of danger signs, utilization of health facilities, and a 14 percent decrease in pneumonia deaths. Reporting of illness also rose initially, an expected consequence of improved disease recognition that should be understood and correctly interpreted so as not to interfere with recognition of gains in health status attributable to the program.

Women's groups contribute to project success

A number of PVOs cited women's groups as key contributors to project success. In Uganda, women's groups initially focused on traditional projects of home gardens and income generation for home health. Increased household income contributed to better nutrition and more utilization of health services by women. In India, women's groups monitor the quality of care. CARE/Kenya found that communities with women's groups more readily identify appropriate community health workers. Mothers' groups in Nepal provide recognition and support that are critical to retaining female community health volunteers.

Noteworthy Approaches

The program used several noteworthy approaches:

- A flexible project structure allowed for changes and innovations recommended by key participants (including CHPs and the community), thus better assuring long-term sustainability.

- Formal representation of CHPs in CHP associations provided a mechanism for planning joint activities between health facilities and CHPs (including fundraising) and provided CHPs supervision and support. This resulted in a heightened awareness of CHP needs by the health system and local government.

- Community-based health surveillance system (CBHSS) where the identification and

monitoring of vulnerable populations resulted in protocols for referrals to health facilities and counter-referrals for household follow-up by CHPs, emergency evacuation plans (including a community decision to procure radio transmitters), and community input on payment schemes.

- An IEC program based on community assessment and preferences with community and cultural dynamics influencing the design of materials and messages as well as channels of communication.

- Ongoing training of health facility staff in clinical and management issues maintained their supportive role.

Motivation Model

Motive	Definition	Activity
Achievement	Setting challenging goals	Training—curriculum reflected community-identified priorities
Affiliation	Establishing/maintaining relations	Community involvement in formation of support groups achievement day(s)
Extension	Relevant/useful role	Community recognition of health accomplishments (health achievement days
Influence	Making an impact	Status within community; acknowledgment of CHV accomplishments, especially by local health personnel
Dependency	Desire for the help of others and approval relationship	Supervision; preferential treatment of CHVs by local health authorities
Control	Monitor and take corrective action	Clear role for CHVs with health facility staff for HIS

Adapted from El Salvador Community-Based Child Survival ProjectBased on BASICS' draft CHW Incentives & Disincentives paper

Catholic Relief Services (CRS)/El Salvador

The long-term sustainability of CRS' child survival program depended on community-based practitioners. When a mid-term evaluation indicated high attrition among community health volunteers (CHVs), CRS designed and implemented an incentive system to reduce attrition. The multiple incentive plan (MIP) targeted six aspects of motivation for community involvement, participation, and mobilization (*see table below*).

Application of the MIP model resulted in dramatic reduction in attrition among CHVs. The exception was in one community where new lucrative employment opportunities drew CHVs away from the project. The five-year project was able to demonstrate a positive impact on a number of key health indicators including appropriate nutrition practices and home care of child illness. It also improved the recognition of danger signs resulting in a 64 percent increase in appropriate care seeking at health facilities.

In creating support for CHVs from many corners, the MIP can contribute to long-term sustainability. Some key elements of this strategy include the following:

Community mobilization: elected health committees and community health volunteers

Public recognition of health accomplishments: strengthened organization of CHVs

Health facility workers linked with CHVs: participation in training, support and acknowledgment of CHV role

Community-based surveillance system: information for a client-oriented social communications strategy and for planning and monitoring health programs CHV training and support: curriculum reflected expressed community needs; CHV role defined in written agreements with MOH at national, district and local levels

7.5 Challenges for sustaining volunteer community health workers

Whether or not to pay CHWs in order to increase retention is a question that PVOs continue to examine. The JSI/PVO collaborative program in Nepal has experienced relatively low attrition among volunteer CHWs. The project has found that local married women, selected by their communities, are able and willing to serve as volunteers without cash incentives, and continue to perform well if regularly supervised. However, external monetary incentives can have a substantial negative impact on the retention of volunteers. In El Salvador, non-monetary incentives were insufficient to combat the allure of lucrative new employment in one project community. Some programs, recognizing this, have decided to integrate income-generating activities into the set of interventions to allow for community compensation or reward of the CHV.

7.6 Partnerships to Achieve Scale

At this, and at previous meetings, PVO presentations clearly demonstrated the wealth of PVO experience with HH/C IMCI. They documented the myriad ways in which communities can be engaged in all facets of child health programs. Today, the challenge facing partners—governments, donors, and PVO/NGOs—is how to extend these successes to all communities within the context of a national strategy. As WHO urges national governments to establish structures and policies that will encourage and facilitate IMCI, how can PVO/NGOs with pilot projects and small local programs help to enrich national, provincial, and district planning? How can these successes be 'scaled up' to reach the greatest population?

Scaling up of successful initiatives may occur in a number of ways:

- Technical expansion (e.g., from a single intervention like ARI to full IMCI)
- Geographic expansion (e.g., from one or two villages to an entire district)

- Expansion within the HH/C IMCI framework (e.g., from work with health facility-community relations/activities in Element #1, to also include work with community-based practitioners in Element #2)

While a single PVO may lack the financial, technical or human resources to take their own successful project to scale, PVOs have successfully expanded the reach of important program initiatives by partnering with other NGOs and/or with the local government, thereby expanding the network of skills and resources. The examples that follow demonstrate the role partnerships can play in scaling up one set of interventions for greater coverage (Nepal), in coordinating multiple interventions for national scale planning (Uganda), and in creating a unified vision and rationale for program direction (PAHO/Latin American PVOs).

7.7 Taking Activities to Scale

How can PVOs take community-based activities to scale without losing the essential elements of success?

1. Organizations should look internally for opportunities to expand and integrate with other sectors where they are working. They need to seek opportunities to share experiences with others working in the same districts (other PVOs/NGOs, district level personnel).
2. By increasingly emphasizing peer training (e.g., mother to mother, community to community), PVOs can decrease dependence on outside trainers and decrease the cost of taking programs to scale.
3. PVOs should continue to create environments in which community representatives feel free to express priorities and concerns. In this way, scaling up can occur without losing the ability of a project to meet the unique needs of each community.

4. PVOs need to build new partnerships and expand existing ones. Networks can attract more resources than a single organization. As with PROCOSI in Bolivia and the NGO Steering Committee in Uganda, a critical mass of involved parties can attract greater attention and resources.

5. PVOs should seek opportunities to mainstream and incorporate successful innovations into their other programs.

6. Successes and lessons learned must be documented. It is especially important to document the continuing impact of an initiative after completion (as done by Save the Children in Vietnam), to garner the interest and support of new partners and donors.

7. It is helpful to demonstrate the relevance of initiatives within the context of the larger national plan, and show district health personnel how a successful approach can help them achieve their goals.

8. PVOs can create centers of excellence or living universities where others can experience the intervention or strategy and learn how to replicate it. The World Vision CSP in Kwazulu-Natal is now a Provincial Learning Center.

7.8 Successful field experiences with scaling up

HH/C IMCI Partnership (JSI, ADRA, CARE, PLAN, Save the Children)/ Nepal

JSI's early experience in Nepal indicated that significant reduction in under-five mortality could be achieved using trained female community health volunteers (FCHVs) for pneumonia case management. The success of the approach was made clear in the evaluation which found that more than twice the percentage of expected pneumonia cases received treat-

ment in intervention districts (from FCHVs and health facilities) compared to non-intervention districts (health facility only). More than half of the cases in the intervention districts were treated by FCHVs. These results coincided with the emergence of a new national health strategy that included a goal to reduce pneumonia mortality.

In order to expand the reach of this successful pilot, JSI and the MOH solicited the involvement and support of partner NGOs. Project coverage grew from three pilot project areas in 1988 to 15 districts representing 30 percent of Nepal's under-five population. The focus of the project expanded beyond ARI to include additional technical components. Expansion was the result of intensive monitoring and comparison of different intervention models. At each phase of scale-up, the responsibilities of all partners were carefully

Any hope for sustainability that makes sense must build on the community's capacity to continually adapt.

-Larry Casazza, World Vision

examined. As the program expanded, new partners received thorough orientation on the elements considered most crucial to program success. Their role in maintaining the monitoring and supportive supervision of the FCHVs was deemed particularly important. At the same time, local and district levels were engaged to provide continuity and sustainability.

Factors contributing to project success

The following contributed to the project's success, at the beginning and through scale-up:

- Self-selection of new NGOs based on willingness to comply with the established model
- Credibility for FCHVs engaging in treatment, achieved through careful comparison

and formal evaluation of treatment and referral model vs. referral only model; FCHVs received intensive training and monitoring

- Training health facility staff concurrently with new FCHVs was critical for program acceptance and for referrals; supervision of FCHVs important for continued high performance
- Active engagement of community support through orientation meetings, mothers group meetings to share knowledge, and FCHV dialogue with community leaders working on cost recovery schemes and other solutions to local problems

BASICS II and PVO partnership, Uganda

Formation of an NGO steering committee in Uganda provided a critical mechanism for PVOs/NGOs to bring their experience to the table and promote HH/C IMCI at the national and district levels. Historically, NGOs played a significant role throughout Uganda in district and local health and development projects. The Ministry of Health's sector strategy promoted decentralization and recognized the important role of NGOs in local capacity building for HH/C IMCI. How exactly to coordinate NGO input into the national process and integrate HH/C IMCI into existing NGO programs were questions that led BASICS II and PVO/NGOs to form their crucial partnership.

The NGO Steering Committee facilitated dialogue among NGOs and between the government and NGOs at two important levels:

District Level: joint planning by NGOs with MOH district health officials in areas where NGO programs span all elements of the HH/C IMCI framework. This forum also permitted better NGO advocacy for allocation of resources to related areas such as child rights and education of girls.

National level: NGOs, through the steering committee and representation in the CORE IMCI Working Group, are able to bring their experience to bear on national policy formation, the development of guidelines for IMCI, and MOH planning. NGOs also re-

ceive important feedback. A Memorandum of Understanding clearly outlines the roles for the government and the NGO Steering Committee. The MOH allocates donor funds in a sector-wide approach - through improved interagency communication, available resources for IMCI are more readily identified and more efficiently utilized. The allocation of these resources to NGOs for HH/C IMCI work provides a tangible indicator of the success of the Uganda partnership. Though this partnership mechanism begun as a steering committee for IMCI, it has taken on a broader role, providing leadership and coordinated action for other technical issues (e.g., GAVI, HIV/AIDS).

The BASICS II project, working collaboratively with CORE's IMCI Working Group, has been an important catalyst for PVO partnerships in Uganda. BASICS II continues to play a critical role in the partnership:

- As an advocate at the national level for NGOs
- As an advocate and technical support organization at the district level for joint government/NGO planning and implementation of HH/C IMCI (and for NGO participation in district IMCI working groups)
- As a facilitator for sharing lessons learned between government and NGOs and for sensitizing NGOs on national HH/C IMCI strategy (including assessment and documentation of experiences)
- As an advocate for increased recognition of the important role of NGOs

PAHO and PVOs in the Americas

Since the early days of the first Global Review and Coordination meeting in the Dominican Republic, PVOs have taken a proactive role with the Pan American Health Organization in contributing region-wide to the household and community component of IMCI. The PVO community contributed technical support for materials development and research support of the national implementation process. PAHO invited PVOs to contribute to several regional policy forums (e.g.,

the Regional Workshop on Talking to Mothers and the Ecuador Planning Workshop on HH/C IMCI). The increased participation of PVOs/NGOs in national-level IMCI policy and planning substantially increased cooperation between PVOs and PAHO, and improved the overall capacity of the PVO community to implement HH/C IMCI.

The PVO community can build on these first steps to solidify the partnership and enhance HH/C IMCI in the region at two levels:

- **Within the PVO community** through mapping of PVO resources as well as strengths and weaknesses by country, delineation of roles/responsibilities, and in-country coordination. In strengthening their region-wide network, PVOs can advocate more effectively for in-country support of HH/C IMCI.
- **With PAHO**, PVOs can take a lead role in forging an institutional agreement as the foundation for regional and national commitments to HH/C IMCI.

By working in partnership with PAHO and building on the recognition of PAHO's leadership status and credibility with national governments, PVOs gain an entry point for a key role in national discussions.

7.9 Challenges for Scaling Up

As PVOs look to scale up successful interventions, and donors and governments seek to reach larger populations, a number of important questions must be addressed. These revolve around three issues: resources needed for scale-up, the focus of the intervention, and the intervention's sustainability.

- **Resources** for HH/C IMCI, whether in-kind or monetary, may come from a combination of sources: the community, block grants associated with decentralization, other government funds, PVOs, and other donors. It is important to determine what human and institutional capacity exists and

what full-scale HH/C IMCI will cost. It will also be important to provide sufficient resources to the community, PVOs and district without exceeding their absorptive capacity for funds.

■ What is the *focus* of scaling up? Will the intervention be scaled up to a larger geographic area? Will additional technical interventions be added? Or will it target additional institutions, partners or practitioners? It is important to plan all aspects of the scaling up. Where will expansion begin? How will it proceed? What organizations will participate in the partnership? How will their involvement be coordinated? PVOs need guidelines for ini-

tiating partnerships like the Uganda NGO Steering Committee.

■ How will the intervention be *sustained*? Is there a plan to build institutional capabilities for HH/C IMCI? A national framework and unified vision for HH/C IMCI can help to bring together key stakeholders.

PVOs bring a wealth of experience to HH/C IMCI. They can and should become active partners in scaling up HH/C IMCI for greater coverage. It is incumbent upon PVOs to step forward and articulate their ideas on the above issues to donors and national planners.

8.0 Leadership: What Role for PVOs?

The PVO community has been called upon to provide leadership -- leadership for HH/C IMCI among NGOs, leadership with the community and at the district level, leadership for the national discussion on implementing full IMCI, and leadership for the global sharing of lessons learned.

PVOs have tremendous opportunities to advance the agenda for HH/C IMCI. They can document local successes and lessons learned, they can articulate the advantages of the HH/C IMCI approach to authorities, and advocate with national policymakers and international donors.

PVOs can be a powerful advocate for child health and nutrition and for IMCI at the community level.

-Flavia Bustreo, World Bank

8.1 What competencies do PVOs bring to linking community with the health system at the district and sub-district level?

PVOs have a demonstrated ability to engage communities in health decision-making through community empowerment and capacity-building of community organizations. It is critical that, at the same time, they leverage their influence to build support at the district level for a community role. PVOs/NGOs are able to successfully advocate for strong community-district links because of the following:

Credibility with the community: PVOs are sensitive and responsive to community needs; they work to empower communities to express and act on local priorities.

Credibility with the health system: PVOs bring resources, technical skills and organizational capabilities, and the ability to mobilize communities to enhance district health programming; they are skilled in generating data for decision-making. PVOs are acknowledged for many contributions to overall quality

of the health system through shared training, supervision and operations research.

Relations with both the community and the district: Credibility with both the community and the district allows a PVO/NGO to serve as a translator to engender meaningful dialogue for common goals.

Special skills or information: PVOs frequently partner across sectors and organizations and are linked to projects and experiences worldwide; access to state of the art technology makes PVOs a valued resource for communities and district planners.

PVOs can apply these capabilities to leverage institutional and district commitment to engage communities in planning and implementation. They work with MOH personnel, encouraging them in their outreach efforts to deal with a broader base in the community. They provide not only technical training, but also training in participatory activities and in drug management and supply. They may use transportation and other incentives to encourage greater outreach by health workers and to build institutional capacity to work more closely with communities.

Measure only what is absolutely necessary, as simply as possible, in time so that it can be used to improve service delivery.

**-Ellen Vor der Bruegge,
Freedom from Hunger**

8.2 How can PVOs contribute to national planning for HH/C IMCI?

In light of their extensive experience with communities and with child health, PVOs can play a critical role in the development of a national framework and unified vision for household and community IMCI.

In many countries, the MOH and/or UNICEF lead the national dialogue for health. PVOs would not supplant this leadership, but would lead in developing strong PVO/NGO partnerships. PVO partners can bring to the table a common understanding of HH/C IMCI and a common vision for the role of PVOs and NGOs in IMCI. If PVOs enter the national policy arena as a unified group, they can achieve a great health programming.

As a group, they can lead in the following areas:

- **Assessment:** mapping coverage needs and resources to help define the agenda for HH/C IMCI; identifying and communicating community needs and priorities

- **Team building:** creating a common understanding of HH/C IMCI for planning and policy purposes through “modeling” collaborations among themselves and their partners

- **Demonstrating and documenting impact:** sharing important studies and lessons learned, and using these for training and advocacy; coordinating with other PVOs to evaluate programs; conducting site visits

- **Advocacy:** using existing research and experience for evidence-based advocacy on what HH/C IMCI can do; developing policy papers to advocate for policy reform on the basis of documented experience with HH/C IMCI; writing proposals for funding; developing a country-specific advocacy kit based on all of the above

- **Empowering communities** to advocate for themselves

8.3 Advocacy

PVOs have engaged in community-level advocacy for years—promoting behavior change, especially for health. Advocacy at the national and international levels—to motivate public and media interest as well as political and financial support—requires different strategies. Advocacy at all levels requires patience and a motivating vision or goal. Achievable targets and timelines can help energize people and mobilize support. Both targets and timelines should reflect solid scientific information so that goals can be reached with available resources. An excellent example of the power of mobilization is the fact that last year in India, over 140 million children under five were immunized in a single day.

Advocacy for HH/C IMCI should target non-traditional partners as well as traditional partners. When the leaders of the G-8 nations mobilized behind the Massive Effort Against the Diseases of Poverty last year², they sought support from a surprising diversity of organizations. At a follow-on meeting in Winterthur, Switzerland (October 2000), churches, advertisers, MTV, and financial institutions, among others, found common ground in the desire to assure the health of children and their families. Uncommon goals call for uncommon coalitions.

At the same time as this international push in health, preparations are underway for a UN Special Session on Children to reassess progress a decade after the Declaration on the Rights of the Child was ratified by many nations. These two events have created an ideal climate in which to advocate for HH/C IMCI. World leaders have begun to consider scaling up of successful health efforts.

Additionally, a powerful argument in favor of investment in IMCI comes from the 1993 World Development Report (WDR) of the World Bank. The WDR ranked IMCI as the most cost-effective public health intervention, citing the following characteristics:

²The Massive Effort Against the Diseases of Poverty is the result of commitments by leaders of the G-8 countries at their 2000 meeting to decrease health burdens from “infectious and parasitic diseases, most notably HIV/AIDS, tuberculosis and malaria, as well as childhood diseases and comm. Infections.” [excerpted from the communiqué at the close of the 2000 meeting of the G-8 leaders.] The G-77 leaders also joined in support of this massive effort.

- Emphasis of IMCI on quality and performance of health services
- Emphasis on essential health services that are an integral part of the World Bank's Health Sector Reform Agenda
- Emphasis on inputs that can have a significant impact on health outcomes (improved prevention and care)
- Focus on health outcomes of the poor

As PVOs mobilize to advocate for resources in support of HH/C IMCI, they should be guided by the following recommendations:

- Clearly define needs
- Understand the target audience and tailor concise messages for that audience
- Use celebrities and select them carefully
- Set concrete achievable targets and a timeline for results
- Use targets and indicators to monitor performance, hold politicians accountable, and maintain momentum
- Exploit opportunities—such as international events—to generate local and media support and to highlight country achievements and commitments

Above all, PVOs need to recognize their role in HH/C IMCI programs to date and make their voices heard. A clear-cut example occurred in Senegal, where the World Bank began negotiating funding last year for a \$30 million community nutrition program. A consortium of NGOs and BASICS project staff successfully articulated the importance of placing the nutrition program in the context of national work with HH/C IMCI. PVOs were able to advocate with authority and legitimacy based on years of work with communities in Senegal.

8.4 What tools could help PVOs advance the national agenda?

Participants identified several resources that would help PVOs carry out their role in national advocacy upon returning to the field.

- UNICEF support in-country (financing) to organize an inter-agency meeting of all stakeholders, based on the model of this workshop. The meeting would focus on:
 - establishing a common understanding of HH/C IMCI and
 - sharing lessons learned and state of the art technology (SOTA).
- Tools to document the cost-effectiveness of HH/C IMCI; other research for use in advocacy
- Guidelines:
 - on integrating HH/C IMCI in different countries (centralized vs. decentralized health system)
 - on advocacy (for PVOs; for communities)
 - on how health policies are established at national level and what influences them
- Funding for HH/C IMCI

8.5 A Model for PVO Leadership in HH/C IMCI

Kate Jones of USAID's BHR-PVC, which supports PVO leadership through its grants for community health programs, presented workshop participants with a vision for the leadership role they can and should play. A PVO's ability to effectively lead or influence others to achieve health for greater numbers of children should be considered in the context of how the organization functions.

1. Global communications: in this electronic age, PVOs are increasingly linked with their headquarters, broader PVO networks, national planners, and rural areas, making access to new

technologies and sharing of lessons learned easier and more rapid than ever before.

2. PVOs may be ‘shapers’ (activists who create new visions and standards for health, like those who shaped the new HH/C IMCI framework) or ‘adapters’ (who creatively adapt visions or programs to the unique characteristics of a community or country). Both are important to the process of developing and implementing HH/C IMCI programs and expanding them to reach the largest population.

3. The speed of PVOs in embracing new processes (such as the HH/C IMCI framework), evaluating the results, and using the results for decision-making may determine the extent to which they are considered key players. Likewise, the ability of PVOs to document experiences and share them throughout their networks will be important. The CORE Group network can help to disseminate important information for ready adaptation by field personnel.

4. There has been a shift in the role of PVOs from providing services to guiding the process. PVOs are increasingly valued as advisors for program design and implementation, and in this role they encourage more grass-roots involvement, which is in itself more sustainable.

5. Transparent organizations—those that readily share information and technology with others and maintain open financial disclosure—will thrive in an increasingly global society. Those that are open within the organization or community in which they work have a greater tendency toward shared decision-making, which has been demonstrated to be so important in working with communities.

6. Managerial issues may determine the ultimate strength of PVOs. PVOs must seize opportunities presented by evolving technol-

ogy and global communication. They need to commit resources to successes and be willing to abandon initiatives and systems that fail.

7. Partnering organizations that combine different talents and skills, maintaining distinct identities while working toward common goals, can enhance PVOs’ ability to compete for scarce resources. The CORE Group is increasingly favored among donors as a network that provides access to more than 35 organizations at one time. Resources and influence will flow to those who are the most creative at bringing together governments, capital, information, and talent into networked coalitions that create value.

8. PVOs and PVO networks need to market their vision for community IMCI as though it were a ‘product’. PVOs have developed highly successful marketing campaigns for oral rehydration salts and condoms, and even for healthy behaviors. With the same confidence, they should market the importance of community IMCI and the approaches they have found successful. Together, PVOs form a powerful coalition dedicated to advancing the goal of health for all, with strong participation by the community in achieving that goal. They have what is required to lead the charge for health for greater numbers of children.

8.6 PVO Leadership

As PVOs bring their vast experience into national discussions on HH/C IMCI, they will need to lead through innovations that increase effectiveness and ensure sustainability while scaling up to reach larger populations. Innovations may be applied to program management to achieve goals and objectives with existing resources. Innovations may be used to develop and improve specific interventions or improve overall program design and development. As with the introduction of the Multiple Incentive Plan in El Salvador and the examples that follow from Project Hope and Freedom from Hunger, PVOs often introduce innovation in response to specific needs. Innovations and op-

erations research should involve the broad participation of local stakeholders in both the design and the use of the results, and should be immediately applicable to the local program.

PVOs increasingly employ operations research to address questions of ultimate goals as well as process. Though some PVOs have their own in-house research capabilities, they benefit from extensive partnering that may include collaboration with research and technical institutions, many of which are in-country. A PVO's presence in several countries provides an opportunity to study one approach at multiple sites. PVO/NGO networks offer an expanded audience for disseminating results, making their research proposals more attractive to a diverse group of donors, including private, bilateral and international organizations.

8.7 Results from the field

Project HOPE/Dominican Republic

Implementation of IMCI at an urban clinic in the Dominican Republic placed severe stress on the budget as well as staff time, and threatened the long-term sustainability of the clinic. In response to these problems, Project HOPE undertook a deliberate analysis of the entire IMCI process of assessment, treatment and counseling with clinic staff. The staff, as primary stakeholders, were called upon to identify constraints in the existing system and participate in redesigning the IMCI form to incorporate sick child visits and home follow-up.

Stakeholder input continued to play a role in testing the new form, in comparison to the old form, and endorsing adoption of the new form. Involving clinic staff in identifying the problem and resolving it enhanced their sense of ownership and commitment to the new form. Staff proudly shared the form with the MOH and with other NGOs, resulting in at least one other organization adopting the form for its own IMCI work.

At the Project HOPE clinic, the new form helped reduce IMCI implementation costs and improved provider practices in assessing high-risk children for home visits and follow-up. It also facilitated improved community outreach, as evidenced by a steady increase in percentage of mothers returning for follow-up visits.

Freedom from Hunger

The Freedom from Hunger Credit with Education Program offers an innovative example of a multisectoral approach to health. Its long-term goal is increased food security and improved health, especially for children. The approach is three-pronged:

1. Credit (village banking) to address poverty through income-generation and personal savings
2. Women's groups (village banks) that foster peer assistance with health and credit issues
3. Health education through weekly village bank meetings and nontraditional channels (village bank field agents)

Multi-year studies of the program in Ghana and Bolivia illustrated the potential efficacy of this approach, but indicated that improvements in child nutritional status were directly related to the quality and quantity of services provided. This evaluation sparked the development of field staff-centered management, an innovative approach for timely feedback to assure quality service delivery. Field staff-centered management extends beyond customary supervision to provide field staff: a) clear and consistent signals (including incentives) about expectations, from recruitment and training through supervision, and b) support, including transportation, supervision, and materials.

Supervisors now maintain communication and timely feedback with field staff through routine progress tracking. With clear goals and regular updates on progress, both supervisors and field staff have access to the information needed to readjust course and reach their goals.

8.8 Operations Research Needs of PVOs

Looking to the future, PVOs have identified several immediate and long-term operations research questions. IMCI-related research to date has focused primarily on health worker performance and costing, with limited research on the community component of

IMCI. Potential areas for operations research for HH/C IMCI appear on numerous lists compiled by WHO, BASICS II, the participants of the February 1999 CORE Workshop, and others.

The following list evolved from discussions on immediate needs for research, within the structure of the new framework for HH/C IMCI. Items in bold indicate top priorities for workshop participants.

PVOs need to continue to network among themselves, partnering on operations research issues of common interest. They can pool their competencies to address many of the pressing research questions on HH/C IMCI. It will also be important for PVOs to engage with other partners (research institutions, governments, donors, etc.) to influence research priorities and add PVO expertise to their research. (*See table next page.*)

An Agenda for Research Related to the Framework

MULTISECTORAL PLATFORM for child health and nutrition (MSP)	<ul style="list-style-type: none"> -What are critical activities/sectors in MSP to sustain HH/C IMCI (e.g., micro enterprise, water & sanitation, leadership development)-compare programs with and without different elements -Demonstrate the complementarity & synergy between MSP and 3 requisite elements -Local governments under decentralization: how to make health a priority for them
ELEMENT #1: Partnership between health facilities and the communities they serve	<ul style="list-style-type: none"> -Assessment of skills needed by communities -How to transfer management skills to community groups -How to increase community input at facility level to improve quality and access -How to involve communities in analysis of costs including opportunity costs -Impact of extended training away from facility on facility-community links: compare benefits of training & effect on links Local community-based management information systems, integration with facility
ELEMENT #2: Appropriate and accessible care and information from community-based providers	<p>CHWs:</p> <ul style="list-style-type: none"> -Are CHWs or volunteers effective? -Maintenance of quality of CHWs -Comparison of incentives for CHWs <p>Private providers:</p> <ul style="list-style-type: none"> -How to improve quality of care by private providers (how to adapt IMCI approach) -Maintenance of quality improvements -Efficacy & effectiveness of traditional practices <p>Other Topics:</p> <ul style="list-style-type: none"> -How to maintain the supply of drugs at the community level, different mechanisms -Skills needed to maintain drug supply -How to promote referral from community-based providers to health facilities
ELEMENT #3: Integrated promotion of key family practices	<p>Basic approaches:</p> <ul style="list-style-type: none"> -How to change community norms-effectiveness of different role models -How to maintain behavior change -How to engage/involve entire household: target decision-makers in household; roles of different family members <p>"Packaging":</p> <ul style="list-style-type: none"> -The best way to introduce package of behaviors <ul style="list-style-type: none"> -sequential addition -promote package from the beginning -clusters of messages that make sense culturally -Interaction between promotion of behavior change and other activities -introduction of new services in health & other sectors <p>Other questions:</p> <ul style="list-style-type: none"> -Testing of different PVO models for promoting behavior change -Community-based health information systems <ul style="list-style-type: none"> -role in advocacy, promotion of behavior change & accountability -impact of feedback of information to community
RELATED TOPICS	<ul style="list-style-type: none"> -Methodologies for setting priorities for action <ul style="list-style-type: none"> -Where do you start within the multisectoral platform and the three elements -How do you take into account stakeholders, resources, epidemiology, etc.? -Comparison of advocacy methods

9.0 Conclusions

Previous conferences and workshops clearly established the critical importance of the third component of IMCI—improvement in household and community health practices. This workshop reached a groundbreaking consensus on a framework for what comprises household and community IMCI. The PVO community has expertise and a long-standing commitment to working with communities for health, as firmly demonstrated by the country experiences presented at this workshop. Just as the participants achieved consensus on the HH/C IMCI framework through a deliberative process, they will need to allow their colleagues in-country the opportunity to arrive at the same conclusions and acceptance.

With the framework as a unifying vision for work in progress as well as work that still needs to be done, PVOs can help to shape the future of IMCI. At the project level, the framework can guide PVOs in expanding to include all elements. In national as well as district-level planning, PVOs can use the framework to advocate for community needs. The framework provides a unifying communication vehicle for discussing HH/C IMCI with colleagues and counterparts and for establishing an implementation

plan. When and where possible, they should bring community representatives to the table.

PVOs must continue to form and manage partnerships for HH/C IMCI at the district and national level to maximize opportunities for scaling up. At the national and global levels, the full force of these networks should be brought to advocating for funding that is crucial to full-scale HH/C IMCI implementation.

PVOs need to successfully share and market their well-documented experiences with HH/C IMCI. They will need assistance documenting other aspects of their work. As PVOs and their partners scale up current programs to include other elements from the framework or cover larger populations, documenting and sharing lessons learned will be critical.

Global leaders are paying attention as never before to the devastating impact of a few diseases on the health of the world's poorest children and their families. PVOs and NGOs, with their cumulative experience, must seize this opportunity. They must advocate for the resources necessary to expand the reach of community IMCI around the world.

APPENDICES

Appendix A - PRESENTATION PAPERS

Appendix B - REFERENCES

Appendix C - SUMMARY OF IMCI 101

Appendix D - AGENDA

Appendix E - PARTICIPANT LIST

APPENDIX A

PRESENTATION PAPERS

Co-Management & Co-financing: A Model to Increase Health Facility Quality of Service & Utilization

Lori Dostal
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Country Background

The status of the Cambodian peoples' health and their health care systems has been affected by the tremendous destruction of life and family, social, cultural and institutional structures including the destruction of human resources during the genocide of the Pol Pot years (1975 – 1979), occupation by a foreign power with resulting isolation and imposition of foreign systems, long term internal and external displacement of a significant part of its population until 1992, and prolonged years of war which only ended in 1997.

Cambodia's health status is among the lowest in Southeast Asia with an infant mortality rate of 89.4 and a child mortality rate of 115 per thousand births, a maternity mortality rate is 473 per 100,000 live birth, and a ranking of 35 in the world's under-five mortality ranking. Leading causes of death among children are acute respiratory infections, diarrheal diseases, dengue haemorrhagic fever, and malaria¹. Malnutrition is a contributing factor in mortality rates for mothers and children. The Tuberculosis prevalence rate is 2.41 per thousand. HIV/AIDS is a growing problem with 240,963 estimated HIV infections and 21,619 cumulative AIDS cases since the first reported HIV case in 1991.

The health care system is plagued by weak management, under-funding, under-utilization of health facilities, competing and unregulated private health providers, lack of basic equipment, medicines and supplies, and low motivation, knowledge and skills among health staff. Under-funding of the health care system and of all civil servants including medical personnel (US \$10 - \$20/month) discourages government health workers from improving quality of public services, encourages them to unofficially charge patients who come for service at the public institutions and to work as private practitioners or at other businesses. The low quality public health services with high and uncertain fees, causes Cambodians to self medicate, use traditional healers and medicine, or to seek expensive, unregulated often poor quality care from the private sector who will provide care at home and will allow payment on time. Cambodia has one of the lowest health service utilization rates in the world with the average Cambodian having only 0.35 medical contacts with organized health services per year.

¹Ministry of Health, Royal Government of Cambodia, 1998.

Overall per capita health expenditure in Cambodia is approximately \$26.50 per year. The Government's contribution to the costs was \$1 per capita in 1998. Household payments (\$20 per capita) are the largest contributor for health care costs. With a GNP of \$260 and at least 36% of the population living below the poverty level the cost of health care contributes to increasing poverty. A recent study found that over 40% of landless people had lost their land due to costs incurred from illness.²

CRS Project Background

In 1993, CRS began a Community Health Project in Battambang Province, in northwest Cambodia where the resident population joined by large numbers of returnees from the Thai/Cambodian Border camps continued to face conflict, and displacement until 1997 when relative peace allowed people to return to their homes and opened up the Khmer Rouge zones for migration, settlement and assistance.

The initial project supported infrastructure development, improvement of management systems at district hospitals, improvement of Maternal and Child Health practices, and strengthening of clinical services provided by the district and commune levels of the Department of Health. Health Center utilization rates and coverage of outreach activities such as immunizations were low. In addition, knowledge levels of community members regarding health promotion and disease prevention measures were low and diseases resulting from poor health practices, unsafe water and inadequate sanitation were frequent. To address these issues and to better serve the needs of the population in the project area, CRS developed and began implementation of the Community-Based Primary Health Care Program (CBPHCP) in two districts in Battambang Province in 1994.

The CRS Community-Based Primary Health Care Program (CBPHCP) Model, is a two pronged approach combining work at the community and health center level, to better address the health status and health care needs of rural communities. This approach emphasizes the importance of community involvement in prevention of disease and promotion of health through the establishment of community based structures and village health activities, while simultaneously strengthening Department of Health services at the health center level to meet community needs and linking the two through a sustainable strategy of the Health Center/Community Co-Management and Co-Financing Committee (CMCF). The government health staff at the Operational District and Health Center, the community health workers and structures and the communities are the CRS CBPHCP partners in implementing this project.

Village Health Structures

In the CBPHCP, CRS has developed, trained and supported three types of community health structures composed of people who live and work at village level and have a specific role and responsibility for improving the health status of their communities with the health center and with the communities in which they live:

² Oxfam Great Britain, June 2000, Interim Report On Findings of Landlessness and Development Information Tool (LADIT) Research, Sept. 1999 –2000. Oxfam GB Cambodia Land Study Project.

Village Health Committees (VHCs) are people elected by their communities to be responsible for management of village health activities, community health education, village water and sanitation projects, referrals, participatory rural appraisals, monitoring and evaluation using assessment tools, and community mobilization

Village Health Volunteers (VHVs) are volunteers (no salaries) responsible for community health education, facilitating immunization and other health center outreach activities, village health information system, referrals, and information flow about the health situation through regular meetings and continuing education at health centers

Traditional Birth Attendants (TBAs) are the women (usually elderly) in the village who deliver over 50% the babies in the rural areas. They are provided with training, delivery kits and continuing education.

Improvement of Health Center Services:

The focus is on developing and improving management systems and clinical services, i.e. the financial system, pharmacy, staffing, infection control systems, improved case management for antenatal care for pregnant women and common diseases in children and improved coverage and care by outreach activities. CRS developed Quality of Service Checklists for common diseases and management systems as tools for the evaluation. Account systems were developed, staff were trained in how to use the system, and a costing exercise was done to determine health center operating expenses. From the costing exercise it was determined that the health centers needed an average of \$50 per month to meet monthly, semi-annual and annual expenses for health center operations. At the beginning, CRS provided this amount to the two pilot health centers, as they had neither a budget nor a means to generate income for operating expenses. It was understood that when the Health Center was able to generate this money, CRS would stop providing the funds. Regular follow-up and monitoring by CRS staff in conjunction with the Health Center staff using the account system checklist was established.

National Health Coverage Plan for Cambodia

The National Health Coverage Plan for Cambodia implemented by the government health system in 1996, reorganized the health care system in an attempt to decentralize, improve utilization of scarce technical resources and improve coverage of services. The Provincial Department of Health was to provide technical and management support to the Operational Districts (OD) which each have the responsibility of managing and providing services to 120,000 to 200,000 people. Each OD has a management staff, a referral hospital and health centers which cover approximately 8,000 to 10,000 people each. Establishment of the health center Minimum Package of Activities (MPA), the standard for health center operations including nursing care and treatment of common diseases, prevention from diseases through outreach activities, health education and working with Village Health Volunteers, Traditional Birth Attendants and Village Health Committees, and management of health center services was established as an essential part of this plan in 1997. The government also recognized the need for community contributions/payment for

health services and supported the development of pilots for co-management and co-financing committees for community participation in financing and management of health center and referral hospital services.

Co-Management and Co-Financing Committee

In mid-1998, after working with the Provincial Health Department, health centers, communities and local authorities, CRS proposed a Co-Management and Co-Financing Model, obtained agreement and permission from the Provincial Health Department and the local authorities for the Model and began the implementation of Co-management / Co-financing (CMCF) at the two health centers in which accounting systems had been established. It was hoped that the model would become a strategy for ensuring health center quality of service, sustainability and community involvement in the management and financing of primary health care services.

Principles for Development of CMCF

- Collaborate with existing structures: government health system, local authorities and communities
- Participation at health center and community level is essential
- Control of the process should be by the community as much as possible
- Capacity building for the community and health center to manage the process should be build into the development of the committee
- The community needs to understand the objectives, process and responsibilities of the committee
- There must be feedback from the community to the health center and the health center to the community
- There must be a process for problem solving
- There should be review and evaluation of the process

Process for Development of CMCF

The objective for the development of the Co-financing / Co-management Committee was initially defined by the Health Center staff and CRS and then reviewed, revised and accepted by the CMCF Committees. The objectives are to:

- Improve and provide quality control of Health Center MPA services
- Promote transparency of Health Center operations and finances to the community
- Improve the overall management capacity of the health center and the community
- Set co-financing / co-management policies agreeable to health providers (health center) and users of Health Center services (community) including fees for service
- Increase the sustainability of the Health Center
- Increase utilization of the Health Center
- Increase resources for Health Center operations
- Increase motivation of Health Center staff
- Facilitate flow of information from the community to Health Center and the Health Center to the community
- Create a system for community “ownership” of the Health Center in which the community partici-

pates in the management and financing of their Health Center.

The Roles and Responsibilities of the Members of Co-financing / Co-management Committee were defined. The members were to:

1. Set co-financing / co-management policies, including fees for services, that are agreeable to communities and Health Center staff.
2. Actively solicit ideas, concerns, and needs from the people they represent (communities, Health Center staff) and bring these to be discussed with the CMCF Committee.
3. Provide information from community to health center and health center to community ensuring that this information reaches all those who should be informed regarding activities, problems, concerns and health situation.
4. Coordinate activities i.e. outreach activities requiring participation of communities and health staff in collaboration with other village level structures (VHV, VHC, TBA).
5. Monitor Health Center use and maintenance of equipment, supplies, medicines, and facility and finances
6. Monitor and provide feedback on the quality, accessibility and availability of health center services and activities
7. Abide by the Bylaws and Contract of the CMCF Committee
8. Attend Co-financing / Co-management meetings one time per month
9. Report all meeting outcomes, plans, decisions to Commune Authorities

The role of the authorities, especially the commune chief and upper levels of the health system were carefully considered and defined in order to maintain the control of the committee with the community. Local authorities were seen to be potentially helpful in assisting the Co-financing / Co-management Committee in solving problems that they might face in meeting their objectives. It was recognized that through their meetings with all village chiefs commune chiefs could help to disseminate information about health services and the CMCF Committee's activities. The committee in turn was responsible to keep the local authorities informed so they could fulfill their important role of supporter. However, neither they nor the Operational District or the Provincial Health Directors or staff should be in charge of the CMCF Committee.

The CMCF Committee is composed of two elected community representatives from each village (one woman and one man), and two health center staff (the Health Center Chief and Accountant). Criteria set for selection of community representative candidates are that they live in the village, be between 35 – 50 years old, be able to read and write, not be a Village Chief, leader of the Village Development Committee or other village committees or hold a government position, be active and willing to serve the community. To ensure the presence of women representatives, women and men were elected separately. The man or woman who got the most votes was the designated representative with the other being the alternate. In the first two CMCF elections, 51.5% of the representatives elected were women. (Both health center chiefs are men and both accountants are women) Both representatives and alternates

receive training and participate in activities so they can understand the process and be able to represent their communities when needed. After election, the committee identified or elected a Committee Chief, Deputy Chief, and Recorder. The Health Center Chief and accountant cannot be the Committee Chief or Deputy. Both CMCF Committees chose men to be chief and deputy chiefs and women to be secretaries. The Health Center Chiefs were both men and the accountants both women.

As the whole process was new to both the community representatives and the health center staff orientation and capacity building were needed. This included:

- Identifying the role and function of the CMCF Committee and of its members
- Developing CMCF objectives and bylaws
- Orientation to the health center by health center staff on health center services and MPA
- Learning about the health structure, health center finance and inventory systems
- Costing exercise to show CMCF the gaps in the budget
- Reporting information to the community
- Understanding the role of the feedback committee members (VHVs, TBAs,) and their responsibilities in the village
- Conducting effective meetings
- Problem analysis and solving
- Collaboration

Setting Health Center Fees and Exemptions with Community Involvement

One of the most important activities conducted after the CMCF Committee is formed is the setting of fee schedules for health center services. The process used in this model is designed to set appropriate fees according to the ability of people in the communities to pay. This requires the input of the Community Representatives and the people in the villages that they represent.

Informal surveys to obtain the ideas of the community about appropriate and affordable fees for each of the services, i.e. outpatient consultation, birth spacing, antenatal care and delivery are conducted by the community representatives. It is essential that the CMCF members get the information from various social levels and from a sufficient numbers of people in the community so the information is representative. The community representatives must not provide information to the community about what they or the health center think the fees should be so as not to bias the people. Information gathering can be done individually or in groups. After all the information, has been collected, each community representative presents the suggested fees from their village, the number and from whom they collected the information to the committee so they can determine if they have sufficient and representative information to make the decision or they need to obtain more information.

The health center members of the CMCF Committee meet with the other health center staff and discuss their ideas for appropriate fees, considering the health center operating and other expenses, what they would like to have eventually for incentive, and what they feel would be a fair fee for the service. These are

also presented to the committee. The suggestions are compared and differences discussed. Ideas from the communities are given more weight than those of health center staff. When the CMCF Committee members reaches a consensus on appropriate fees for each service they take this back to the community for validation. If the community agrees the fees are established. The finalized fee schedule is then posted on a large sign in the health center and on information boards in all the villages along with the list of health center services available.

At Phnom Sampho and Khnach Romeas Health Centers fees ranged from 500 riel for first OPD, to 100 to 200 riels for the follow up visits and follow up malaria smears, 5000 riel for deliveries, 1000 riel for dressing change or minor surgery, birth spacing visits and supplies and first time malaria smears. (Exchange rate – 3900 riel = \$1.00) (GNP = \$260)

The issue of exemptions is an important part of developing a fee schedule. Health Center and community representatives all agreed that there are poor people who will not be able to afford care even at very low prices and should automatically be exempt from paying for health center services. However, the problem was how to identify the poor. There are no regular tax records or other documentation of income or assets in Cambodia and although people know each other in the village, health centers have patients who come from other areas that are not in their normal service area. After much discussion, the Committee decided that health center staff should give exemptions to those people who came to the health center and said they had no resources to pay. The CMCF members felt that, generally, people from the rural villages in Cambodia will pay for a service if they have the money and the fee is reasonable. In the year 2000, the average exemptions per total monthly OPD visits were 15% of the total.

Other CMCF committees in other areas have issued cards from the community representatives or developed a list of people identified by the village leaders. None of the systems are totally satisfactory. In the future, other ways of identifying the poor such as wealth ranking will be tried.

It was also decided that those people who worked as village level health volunteers should also be exempt from paying for service as an incentive for them. They were given an identity card. Buddhist Monks and children referred from school were also exempt.

Health Center and Community Contract

The Ministry of Health requires the CMCF Committee to develop a Health Center / Community Contract. The contract documents the operation of and the agreements made by the CM/CF Committee, e.g. the health center fee schedule, CM/CF Bylaws, monthly meeting and reports, health center responsibilities, work schedule, services. The responsibilities of the Operational District, and the Provincial Health Department and local authorities are also included. In the contract, the community agrees to pay the fees for services set by the CMCF Committee, to participate in CMCF meetings, to provide information to the health center and to the community, and to participate in problem solving. Health Center staff agree to provide service at the times and quality and manner agreed on, and to participate with the CMCF

Committee according to the Bylaws. .

After the final version of the contract is prepared it is submitted for signature to the CMCF Chief, Health Center Chief, Commune Chief, District Chief, Operational District Director, and Provincial Director of Health. The contract and a health-financing proposal are then submitted to the community and sent to the Ministry of Health for approval.

The CMCF Committees have agreed to have a health center report of activities and accomplishments, a community report from the representatives, the health center financial report, problems and special events or concerns as regular agenda items for their meetings. At the beginning, CRS took a major role in facilitating or assisting the CMCF Chief in facilitating the meetings. Meeting minutes are taken at each meeting and monthly reports are submitted to health and local authorities as well as to the community. Problems that are identified are discussed and solutions sought. Problems that relate to the health center staff are discussed at their monthly staff meeting or sooner depending on the urgency of the issues and feedback is given to the committee at the next meeting.

Results and Achievements

Collection of and analysis of data on OPD New Cases and Total Cases and Health Center Income were used by the CRS CBPHCP to monitor progress at the two pilot health centers. Both showed increases after CMCF began. The health center was able to generate enough income to cover operating expenses. A team of external evaluators performed an evaluation in May 2000. The methodology for the evaluation used a participatory design. Qualitative and quantitative data was collected through focus groups, in-depth interviews and program HIS of randomly selected villages. Health utilization rates were calculated for selected clinics for the 1998 and 1999. Evaluators found that Health Center Utilization Rates (Utilization Rates = # new cases/total population of area of coverage) for the Health Centers in which the CRS CBPHCP was working showed a general increase. The clinics that had CMCF had higher utilization rates and increased more from 1998 to 1999. Khnach Romeas Health center had a Utilization Rate of 45% in 1998 and 60% in 1999 which was an increase of 33%. This was three times higher than the national average. The Ministry of Health reported a national utilization rate of 20% in its 1998 National Health Survey. Although the rates for Phnom Sampho Health Center were not as dramatic, the Utilization Rate did increase by 18%. Antenatal Care utilization rates also increased. Khnach Romeas increased from 30% in 1998 to 68% in 1999. Phnom Sampho Health Center Antenatal Care utilization rates increased from 29% to 41%.

Lessons Learned and Recommendations

- Without the strong commitment of health staff to improve the quality of their health services and to actively involve community members in the process of developing Co-management / Co-financing, this strategy will not be successful.
- CMCF should not take place before there is an acceptable level of health center service quality,

Health Center Data Prior and Post CMCF Development

Type of Data	Prior to CMCF Jan – May 1998	1998 post CMCF June – Dec 98	Year 1999	Year 2000
OPD Average New Cases	195	461	432	400
OPD Average Total Cases	313	574	571	556
*Average Monthly Income Generated	Donations + CRS budget support - \$50	234,480 riel ** (CRS decreased budget support to \$35)	157099 riel (CRS stopped budget support)	210815 riel
Average Monthly Expenditure	124,690 riel	113,612 riel	167613 riel	155969 riel

* (Exchange rate – 3750 riel = \$1) ** (According to Ministry of Health policy, 50% of health center income was to be spent for health center operations, 49% for staff incentives and 1% for the government. Incentives were not to be taken until after the establishment of CMCF and the Health Center/CMCF Committee contract and financial proposal were approved by the MOH)

regular working hours, appropriate kinds and amount of medicines in stock, effective accounting system, and some interest in the communities in using the health center's services.

- Community health structures (VHCs, VHVs, TBAs, other village health workers) can be very effective in facilitating the implementation of CMCF by helping disseminate information to their communities about the objectives of CMCF before election of Community Representatives and can provide feedback to health center staff during monthly meetings at the health center.
- Linking of CMCF Committee community representatives and other village level workers and structures may need to be facilitated to establish a working relationship between the two and the health center in order to optimize their work.
- Before organizing village elections for Community Representatives and beginning the process of establishing CMCF committees, village chiefs and commune authorities must be informed about the purpose and objectives of the committee, the formation process, and what is expected of these authorities. Information must be provided to community members about the purpose of the CM/CF committee, the role and responsibilities of Community Representatives, and criteria for candidates to allow people to make informed decisions when voting for candidates and also sensitizes community members to the process of CMCF.
- Health center fees must be decided with the input of the communities they serve. If fees are not set according to the ability of villagers to pay, nobody will use the health center. If later, fees are determined by community members and health center staff to be too low, they can be raised. But if fees are set too high in the beginning, then the process will be stopped before it even has a chance to start. Fees should never be raised before re-evaluating the health center quality of service.

- The health center account system must be transparent if CM/CF members and villagers are to have confidence in the staff and feel comfortable to pay fees for service. There should be a health center finance report to Community Representatives during CM/CF meetings and members should be encouraged to monitor accounts and inventory.
- To increase health center utilization, work hours, fees, services available, and medicines and treatments available should be posted/publicized at health centers and in the villages.
- CMCF functions and roles and responsibilities of Committee members must be clearly defined and Committee bylaws must be identified.
- CMCF Committee members should be volunteers and not receive any salary or other benefit besides exemptions from payment for health center services.
- Facilitation and support from NGOs with experience in working with health staff and village health structures can be effective in bringing these two groups together in a system of Co-management / Co-financing.
- Ministry of Health (MOH) must commit to provide adequate medications for health centers.
- The capacity of the health center staff and the community needs to be built to bring about self-management of the process.
- Collaboration with the MOH, Provincial Health Department and Operational Districts is essential.

Future Plans and Expansion

The two pilot health centers have now had CM/CF Committees in operation for more than two years. Committees meet monthly. The Committees have addressed issues of health center service, availability, staff attitude, and community health problems. Both health center and community feel that the relationship between the two has improved, there is a better understanding, and that both are willing to deal with problems. Health Center utilization initially increased by 103% on average for the two health centers and later leveled off at 96%. Quality of service has improved.

Two additional health centers have elected CMCF Representatives, had training and developed Bylaws. They are in the process of establishing fees and developing a Health Center/Community CMCF contract.

These new health centers have less quality of service and less utilization than the pilot health centers had. This means it will probably be more difficult and take more time to develop the necessary level of service quality to allow for successful implementation of Co-management / Co-financing. However, the community health structures mentioned earlier (VHCs, VHVs, TBAs) do exist in these areas and will help to facilitate the process.

Analysis of Community IMCI Implementation Option Framework

The implementation of CMCF in conjunction with strengthening health services and developing the capacity for self management of community structures increased access, availability, utilization, quality of health services at the health center and community level, improved relationships, communication, information flow, understanding and collaboration between the health center and the community and provided the community with some control over health center activities. This intervention lays an important framework upon which to

build facility and community based IMCI. It was helpful that the Ministry of Health (MOH) was open to pilot efforts for CMCF. However, it was still essential to involve the Provincial, Operational District, Health Center and Community level in every step. In this case the model was developed with the health center and community and then presented to the Province and Operational District level and finally submitted to the Ministry of Health. Collaboration with other NGOs working in health and development has been done through on site collaboration, local government/NGO working groups, facilitating and participation in National level NGO Community Participation Working Group resulting in recommendations for the MOH, and representing the NGOs with the government and INGOs for the development of Primary Health Care policies. Present National protocols are based on World Health Organization (WHO) vertical programs, e.g. ARI, CDD, DHF. IMCI is in the process of being developed in Cambodia. CRS Cambodia has been involved in developing Module Three which is an integrated pediatric management module as well as having some input into the IMCI development. Close collaboration in all phase with all levels of the health systems will be important in implementing IMCI. The groundwork for this has been started with the collaboration of CRS CBPHCP with its partners in implementing the present program, in planning for the future project and in discussions regarding the implementation of IMCI. We believe that this level of collaboration will be essential for the development of and implementation of IMCI in Cambodia and hope that it will be possible and encouraged by the MOH, the INGOs who are assisting the MOH in development such as WHO and UNICEF and by the all NGOs working in health and development and that the contribution of each will be allowed in a spirit of collaboration and partnership for the implementation of a very important strategy for improving the health status of Cambodians, not in exclusion due to exclusive ownership or competition.

Community Support for Improving Child Health: Promotion & Network Sustainability

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Overview of the Project Activity

The Child Survival Project of CRS/CARITAS El Salvador was initiated, under USAID/BHR-PVC funding, in 1995. It served 44 communities in three departments of El Salvador's Eastern/Paracentral region. The project targeted children under two (3,550), and women in their reproductive age (2,400) with a total population directly covered by the project of 5,950. The project's goal was to reduce infant and child mortality in children less than 24 months in the target area over a four-year period. Three main areas of intervention were implemented: infant nutritional practices (40%), immunization (30%), and diarrhea control (30%). The project's objectives were:

- Increase to 25% the percentage of infants 0-6 months fed exclusively with breast milk
- Increase to 80% the percentage of children who, during and after illnesses, are given appropriate quantities of breast-milk, semi-solid or solid foods
- Increase to 45% the percentage of women feeding their children age-appropriate food
- Increase to 70% monthly growth monitoring of children under 24 months of age
- Increase to 60% the percentage of mothers who appropriately treat their children for diarrhea
- Increase to 50% the percentage of mothers who seek medical aid when their children have signs and symptoms of severe diarrhea
- Increase to 70% the percentage of children fully immunized
- Increase to 60% the percentage of women who received two doses of TT or a booster during their pregnancy

To reach the above objectives the program included as its main strategy the integration of specific health messages delivered through community volunteers, strengthening of community structures and its links to local health facilities.

Description of HH/C IMCI Intervention

This paper will examine the design and implementation of an incentive system for community health resources, and its impact on retention and sustainability of community health volunteers.

The community was organized through "Community Health committees" and health community volunteers (promoters and collaborators). Committees and volunteers were elected during community assemblies after ample discussion of its roles within the project implementation. The health committee's main role was to promote links with local health facilities, advocacy, and inter-sectoral collaboration; health promoters kept the community health information system and supervised the health collaborators; the latter made home visits and health education. On average one promoter and four volunteers served each community, realizing at least one monthly meeting with the support groups and two

home visits per month to the mothers in order to reinforce behavioral change through health messages about breastfeeding, vaccination, and diarrhea control.

The local level of the Ministry of Health (MOH) provided the curative services. Emphasis was placed onto this collaborative effort with MOH through establishing written agreements with the national, district and local level; with particular effort and success on the local level, as a key for obtaining and maintaining effective relationships.

During the mid-term evaluation of the CRS program in El Salvador (September 1997), a community volunteers' attrition rate of 31% was reported. As a response to this finding and since the sustainability of program activities rested on community-based practitioners, an incentive plan for community volunteers retention was developed and implemented.

Due to the unavailability of project funds to provide economic incentives and the unsustainable nature of this type of incentives in the long term, the program designed and implemented a multi-incentive plan focusing on aspects of achieving self-confidence and leadership abilities utilizing a motivational model (Pareek motivational model). This motivational model focuses on six aspects of motivation: achievement, affiliation, extension, influence, control, and dependency . See table 1 below.

TABLE 1: Motivational Model

Motive	Definition	Activity
Achievement	Setting of challenging goals	Acquisition of skills
Affiliation	Establishing/maintaining relations	<ul style="list-style-type: none"> • Community involvement • Identification • CHW networks
Extension	Relevant and useful role	Community recognition
Influence	Making an impact	Status within community
Dependency	Desire for the help of others and approval relationship	<ul style="list-style-type: none"> • Supervision • Preferential treatment
Control	Monitor and take corrective action	<ul style="list-style-type: none"> • HIS • “achievement days”

Achievement motive was implemented through a participatory training methodology, with training sessions implemented at the community and its curriculum reflecting expressed community needs. The training curriculum besides including topics related to the main interventions (nutrition, immunization and diarrhea) also had a strong component of topics aimed at strengthening the organizational side of the community such as adult communication techniques, administrative and organizational skills, and topics dealing with human rights. Training activities, although being the main responsibility of CRS and its counterpart (CARITAS),

also included MOH personnel. Monitoring of skill achievement was done during training sessions and during supervisory activities.

Affiliation motive (concern for establishing and maintaining close, personal relationships) was done through three main strategies, community involvement, identification devices, and promotion of CHV networks. The community involvement was done mainly through the formation of community mothers and pregnant women support groups, as well as the development of health committees in every village covered by the program.. Mothers and pregnant women groups development were promoted through three main activities:

1. Community diffusion of the program (91.2% of mothers included in the final KPC had knowledge of program implementation).
2. Home-visits to mothers with children under 2 years of age (88.6% of mother had received a visit from the CHV during the last month, according to final KPC), and
3. Implementation of community meetings addressing felt needs and practical and feasible solutions to community limitations.

The final evaluation of the project found that 33% of surveyed mother had participated in these support groups, and 51.3% had participated in community meetings held by these support groups. Identification devices for CHV consisted of ID cards, caps and shirts with the program logo. CHV networks were promoted through village exchange visits, in which the CHVs as a group would visit a community and share experiential testimonies among themselves. During these visits, training activities would be held as well. Also every month the program held a social event with the participation of all CHVs.

Extension motive, defined as the urge to be relevant and useful to larger groups, was sustained specially through periodic (every six months) community meetings: "achievement days". During these achievement days the community recognized health accomplishments of the project as well as limitations encountered, hence, showing appreciation to the work developed by the community health volunteers.

Influence motive or the concern with making an impact on others was also obtained through "achievement days" by identifying accomplishment on health indicators during the previous six months of activities. Likewise, the participation in these activities by local health facility personnel enhanced CHV's status within the community, as well as the establishing of "written agreements" between the community and the local health facility.

Dependency motive or desire for the help of others in one's own self-development/having an urge to maintain an "approval" relationship was sustained by a preferential treatment by local health authorities (fee exemption at health facilities), and the periodic supervision by local counterpart and CRS personnel.

Control motive or desire to monitor and take corrective action when needed was stimulated by the implementation of a simple and relevant HIS to local reality and its links to the local health facility. Also in this regard was helpful that the CHV had clear roles previously established and disseminated by the program. These roles were home visits (20 per month) and counseling to mothers and nursing women of children under two years of age in relation to breastfeeding, nutrition and immunization; supervise support mother/pregnant groups, detection of target population, referral to health facilities, data collection for the program's HIS.

C. Methods, Results, Achievements:

A final evaluation of the program by an external consultant was completed on August-September 2000. The evaluation collected quantitative data through a KPC survey and tabulation of data collected through the program's health information system. Qualitative data was collected through focus groups and key informant interviews. The information related to community health volunteers was collected from the program's health information system.

Exclusive breastfeeding increased by 7%; immunization coverage (OPV3) increased by 24% in children less than two years of age, and by 33.4% (TT2) among women in their reproductive age; and detection of danger signs increased by 43%, which in turn increased facility utilization by 64% among high risk children. See table 2. After 5 years of implementation (4 year plus one year non-cost extension) the project presented the following results.

Table 2. Comparison of baseline and final data indicators and its grade of change over a five year period (1995-2000)
CRS El Salvador Child Survival program

Indicator	Baseline 1995	Final 2000	Change
Exclusive BF<4	22.7%	29.6%	+6.9%
% sick children offered app.food	56%	64.3%	+8.3%
% children w/age appr. food	45%	63.6%	+18.6%
% <24m w/monthly GM	33%	53.6%	+20.6%
% <24m appr. Treated for diarr.	22%	84.6%	+62.6%
% <24m appro. Care-seeking	25%	88.6%	+63.6%
% <12m fully immunized	45%	61.4%	+16.4%
% women w/TT	21%	54.4%	+33.4%

Community volunteers

During the life of the project (1995-2000), 598 community volunteers were recruited in the three communities covered by the program (Santiago de Maria, Zacatecoluca, and San Vicente). Of these, 212 volunteers left the program for a total attrition rate of 35%. During the second half of the program a multiple incentive plan (MIP) for community volunteers was designed and implemented.

Comparing pre and post MIP desertion numbers, we found that in the three communities altogether 59% (126) of community volunteers left the program before the implementation of the MIP, and 41% (86) did so afterwards. This data shows a decrement of 18% in the attrition rate before and after MIP.

When we desegregate the data by community, it was found that the community of Zacatecoluca experienced a negative impact after the implementation of MIP; increasing its attrition rate from 19% to 27% (total attrition rate for this community in the 5 years period was 46%). Complementing these results with qualitative research, it was found that this community experienced during 1996-97 the establishment of several garment factories in the area. The counterpart, CARITAS, during the first half of the program started, as incentive for volunteers, to link the program volunteers with management personnel of these factories to facilitate the employment of program volunteers. Thus, as volunteers started working in the factories their involvement within the program started to decline. In this particular case "achievement" in monetary terms functioned as a disincentive for volunteer sustainability. See table 3 below.

Table 3. Comparison of community volunteers attrition rates by community and pre-post Multiple Incentive Plan (MIP) CRS-EI Salvador Child Survival Project 1995-2000

Volunteers				
<u>Community</u>	Total	Total Attrition rate	Pre MIP	Post MIP
Santiago	247	26% (65)	85% (55)	15% (10)
S. Vicente	129	35% (45)	67% (30)	33% (15)
Zacatecoluca	222	46% (102)	40% (41)	60% (61)
Total	598	35% (212)	59% (126)	41% (86)

Conversely, if we compare Pre/Post MIP between the communities without the monetary (employment) factor, San Vicente and Santiago de Maria (total attrition rate of 30%), we found a decrement between pre and post MIP in volunteer's attrition rate of 54%. See table 4 next page.

**Table 4. Comparison of community volunteers attrition rates among communities without monetary (employment) incentive by pre-post Multiple Incentive Plan (MIP)
CRS-EI Salvador Child Survival project 1995-2000**

Volunteers

Community	Total	Total Attrition rate	Pre MIP	Post MIP
Santiago	247	26% (65)	85% (55)	15% (10)
S. Vicente	129	35% (45)	67% (30)	33% (15)
Total	376	29% (110)	77% (85)	23% (25)

Lessons Learned

- The utilization of multiple incentives strategies based upon motivational models is critical for community involvement, participation, and mobilization, as well as affecting positively retention rates of community health volunteers
- In this program monetary related (employment) incentives had a substantial negative impact on community volunteer retention
- Key factors at the community level affecting CHV retention were community recognition, identification gear, preferential treatment, clear role/expectations, and CHW networks
- Factors that motivate communities to support a CHW system in this program were community involvement in the definition of roles and responsibilities and selection of community volunteers; community support groups with clear, relevant, and feasible goals; health facility recognition; community diffusion of achievements
- An health integrated approach promotes community mobilization
- Educational level among volunteers is neither a factor in affecting retention nor program impact.

Sustained Positive Deviant Child Care Practices and Their Effects on Child Growth in Vietnam

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Save the Children

ABSTRACT

Background: Evaluations of Save the Children's (SC) Poverty Alleviation and Nutrition Program (PANP) in rural communes of Vietnam have documented significant improvements in child nutritional status at the end of the program. A central element of PANP is the use of the Positive Deviance (PD) approach to identify key growth promoting behaviors.

Objective: The objective of the present study was to investigate whether improvements seen during a PANP intervention (1993-1995) were sustained three and four years after SC's departure.

Methods: Cross-sectional surveys were administered to 46 randomly selected households in four communes that had previously participated in PANP and 25 households in a neighboring comparison community in 1998 and 1999. Two children per household, an older child who had participated in PANP and a younger sibling who had not, were measured (total n=142 children), and their mothers were interviewed.

Results: Older SC children tended to be better nourished than their counterparts. Their younger siblings were significantly better nourished than those in the comparison group, with adjusted mean weight-for-age Z-scores of -1.82 vs. -2.45 ($p=0.007$), weight-for-height Z-scores of -0.71 vs. -1.45 ($p<0.001$), and height-for-age Z-scores of -2.11 and -2.37 ($ns, p=0.4$), respectively. SC mothers reporting feeding the younger siblings more than their counterparts did (2.9 versus 2.2 main meals per day [$p<0.001$] and 96.2% versus 52% offering snacks [$p<0.01$]). All SC mothers reported washing their hands "often" while only 76% of the comparison mothers did [$p<0.001$].

Discussion: In sum, growth-promoting behaviors identified through positive deviant studies and practiced through SC's neighborhood-based rehabilitation sessions persisted 3-4 years after program completion. These sustained behaviors contributed to better growth of younger siblings who were never exposed to the program itself.

Indexing Key Words: positive deviant, positive deviance, childcare, complementary feeding, nutritional status, nutrition education, Vietnam, Save the Children

Mobilizing Joint Planning, Action and Monitoring in Oruro, Bolivia

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Project Overview

In 1997-98, the “Community Epidemiology Information System/”Sistema Epidemiológico Comunitario Integral” (SECI) was designed to improve maternal and child health in rural Bolivia by supporting partnerships between indigenous communities and their local health systems with a community-based health information system (CB-HIS). CB-HIS are surveillance systems that collect and track health events occurring in a community outside the walls of the health post or hospital. Generally in projects that have used CB-HIS, the rigorous supervision and technical expertise needed to maintain high-quality research or impact data have limited community participation to the initial needs assessment and periodic consultation about program activities and impact. Few programs or studies have prioritized the community’s access to information from a CB-HIS. In 1998, Save the Children Federation/US (SC) invited ten rural communities and district health professionals in Oruro, Bolivia to use a CB-HIS to assess local health and plan health services together.

The rural department of Oruro, located three hours south of La Paz, is among Bolivia’s poorest as reflected by its health, social and economic indicators. This farming and mining region is located on the high Andean plains at 3700 meters altitude. Health facilities in Health District V where the project is based include eleven health centers, four health center/hospitals, and one referral hospital located in the neighboring district of Eucaliptus.

Differences in culture, language and social status, compounded by geographic isolation, have hindered relationships between health professionals and the indigenous communities of the Bolivian Andes. These peoples are among the country’s most socio-economically and politically disadvantaged groups. Limited community support for and use of health services in rural areas have led many health professionals to conclude that Aymara and Quechua people are uncooperative and disinterested in health initiatives. Indigenous Bolivians may be sceptical of western health care, but they are interested in using effective services that respect their culture and dignity.

The Bolivian government introduced reforms in recent years to make public services more responsive to communities. In 1994, the Law of Popular Participation mandated grassroots representation on district health and social sector councils. In 1995, Administrative Decentralization transferred economic and political decision-making for key public services and resources, including the health system, to regional departments, municipalities, local citizens’ councils, peasants’ unions and ethnic groups. In 1998, the Ministry of Health and Social Welfare instituted universal access to primary care that covered basic

maternal and child health (MCH) services, paid for through funds distributed to municipalities.

The Bolivian National Health Information System (SNIS) was developed primarily to serve as a national and regional planning system and is similar to national health information systems in other countries in Latin America. The system was designed to capture information from health service sites (health posts, health centres and hospitals) at the ‘area’ level (several communities served by a health facility). The information is then moved up a vertical path to districts, departments (states) and finally the national level. The SNIS is not designed to show the health problems and specific demands of each community. Although ‘Committees for Information Analysis’ (CAIs) have been instituted by the MOH as part of the Bolivian government’s policy to support popular participation at the district level, community participation in these committees is generally limited to one or two representatives. The CAIs are a positive step, but often community representatives do not understand the information presented and/or do not feed back this information to the broader community.

Why establish a community epidemiology surveillance system?

As mentioned above, the SNIS was designed to meet the needs of health service planners at the national and regional levels. Because of its facility-based orientation, the SNIS does not register events that happen in the community such as deaths, births, pregnancies and illness when patients do not seek care in a facility. To estimate prevalence rates, more complete community data are needed in addition to service-based data. A community health information system that complements the SNIS can help to develop a more complete picture of a community’s health. Health information belongs not only to health care providers, but also to the community members who generate this information. Community members’ participation in the interpretation and analysis of the information is critical. Service providers working with communities leads to better interpretation and understanding of the information which leads to better planning and greater community participation.

Project Goal

SECI’s goal is to increase the utilization of health services and improve household behaviors to improve the health status of women and children in rural areas of Bolivia.

Objectives

The project objectives are to:

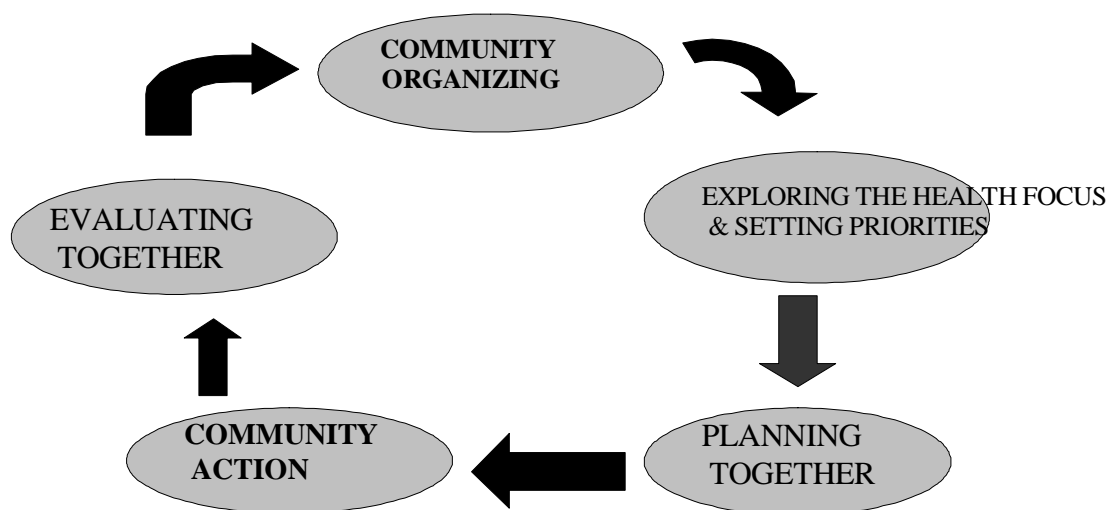
- Increase communication between participating communities and health service providers through the use of a community and facility-based health information system to contribute to improved health.
- Increase participating communities’ and health service providers’ ability to analyze and use information to address community health problems.

In-depth Description of the SECI Project

SECI mobilizes communities and service providers to act together to improve health by increasing provider and community access to and joint analysis of community health data. For the purposes of this paper, we are defining community mobilization as a process through which action is stimulated by a community itself or by others that is planned, carried out, and evaluated by a community's individuals, groups and organisations on a participatory and sustained basis to improve health.

SECI follows a 'Community Action Cycle' process (see Figure 1 below) that has been slightly revised from what was originally used by Save the Children/Bolivia in the Warmi maternal and perinatal health project (de Konig and Martin 1996b; Howard-Grabman 1993)

Figure 1. A community action cycle



Indigenous communities and local health personnel worked with SC staff to develop the CB-HIS for the the SECI project. Using participatory methods, researchers investigated local health problems, beliefs, terminology, local literacy, numeracy, and analysis skills, and traditions of indigenous planning and decision-making. These researchers asked communities whether and how a health information system could be useful to them, studied the strengths and weaknesses of the Warmi project (a SC methodology through which women identified, prioritized, and addressed their reproductive and perinatal health problems) and developed and pre-tested presentation formats and materials.

The SECI project incorporated principles of evidence-based decision-making, health promotion, and non-formal adult education, and sought to promote the values of equity, gender equality, responsibility, accountability, self-determination, and sustainability. The three fundamental elements of the SECI project were community meetings, volunteer promoters, and health information.

The promoters gather health information directly from community families using simple forms and community maps during household visits or at other opportunities. Health personnel or SC fieldworkers work with promoters at the end of each month to consolidate their information (such as the number of children with diarrhea in the last month) with information registered at the health post or hospital.

At regular meetings, a volunteer health promoter and a doctor or nurse from the nearest health facility present citizens with information about the health status of women and children in their community. They present the data using culturally appropriate materials suitable for adults without literacy or numeracy skills. Colorful pictures imprinted on cloth banners depict each of the HIS indicators for women of reproductive age and children under the age five years. Indicators for maternal health include the numbers of pregnant women, prenatal checks, pregnant women with anemia, births attended by trained and untrained individuals, and maternal deaths during pregnancy or delivery. Indicators for child health include the numbers of cases of diarrheal disease, respiratory illness, malnutrition, complete immunization, and child death. In place of numerals, a space above each picture is filled with small paper images of women, boys or girls to represent the number of cases recorded in the CB-HIS. The corresponding denominator is attached to a space at the top corner of each banner. Red, yellow and green color-coding on individual health cards and presentation banners categorize three levels of risk (dangerous, at risk, healthy) and displays indicators such as child growth and immunization status.

As the provider and health promoter present the data using the visual materials, community members and service providers analyze the information and articulate health priorities that reflect the community's perspective. The methodology builds in a series of analytic questions and ways to present the data so that community members and service providers can compare trends over time, monitor progress and determine where alternative strategies are needed. Community representatives share the consolidated information, plans and strategies that have been developed and other results of these community meetings at the district level CAI meetings. As changes are implemented, the health information system continues to help the communities and health staffers work together to monitor progress toward achievement of agreed upon objectives and to make decisions on municipal and community resource allocation.

Volunteer promoters and health personnel have key roles in the SECI project. In addition to helping their communities analyze and understand health information, these facilitators encourage citizens to use the data to prioritize their health needs, develop plans, take action, and monitor progress. By acting as resources for information about potentially effective solutions, they also encourage communities to adopt beneficial health practices and address barriers to the use of local health services. Volunteer promoters and health personnel support the principles and values of the project, and especially encourage women to attend and contribute to the health discussions with the aim of enhancing their decision-making roles and status.

Following SC proposals in the spring of 1998, ten communities and health ministry administrators in Health District V/Oruro agreed to participate and provide facilitators for the SECI project. SC invited established

health leaders, distributors of contraceptive supplies, or health promoters to volunteer as promoters with the SECI project in several communities. Communities that did not have such individuals, or wanted more, selected new volunteers. Larger, more dispersed communities chose two or three promoters. Three of the fifteen volunteer promoters selected for the SECI project were women. Ministry administrators asked the hospital director from each participating community to assign health personnel to the project. SC replaced two communities that dropped out in the first few months when they lost interest or could not coordinate health personnel visits.

Although the SECI project did not include specific child survival and/or reproductive health training for the volunteer promoters, all learned about these topics prior to or during the project. Several had been or became associated with Bolivian Association of Rural Health Promoters, (APROSAR) and others had supported the fore-mentioned Warmi project as distributors of contraceptive supplies. Training varied greatly among the SECI promoters – some had attended a few theoretical workshops, while others had been in service as APROSAR promoters for several years.

In addition to providing training and in-service support for the promoters and health personnel, SC staff helped each promoter to administer a growth monitoring program in their community, and offered transportation for health personnel to attend community meetings and to conduct out-reach activities in remote communities.

SC was conducting other child survival and reproductive health projects in Health District V during and prior to the SECI project. During the SECI project, SC fieldworkers promoted child health to all communities in Health District V/Oruro, including the control communities in this study. The field workers emphasized immunization, growth monitoring, and nutritional education. They coordinated with the Ministry of Health and APROSAR to provide outreach services and health education based upon each community's preferences. SC also promoted reproductive and perinatal health with the Warmi project that ran from mid 1998 to December 1999, overlapping SECI activities in five of the seven SECI communities and one of the seven control communities in this study.

SC and JHU/PCS staff also worked in collaboration with Ministry of Health staff at national, regional, district and community level to develop a complementary software package that was field-tested at the district level. The software package consolidates community level data from health promoters with national health information system service-based data and translates this more complete epidemiological picture into graphics that can be used with communities. Designed to be fun to use, the software package helps service providers at the district level analyse the data to help them plan program strategies.

Methods, Results and Achievements

In June 1999, after one year of implementation, SCF conducted an evaluation of the SECI pilot project in collaboration with Emory University. For this study, a household survey conducted in seven intervention

communities (those participating in the SECI project) and seven control communities (comparable communities in which SCF works) questioned care-givers about knowledge and use of MCH practices and services. Additionally, SCF staff compiled SECI meeting minutes, fieldworker diaries, and correspondence throughout the implementation period.

According to the household survey, SECI households were more likely than control households to use practices and services beneficial to their children's health. Children in SECI communities were over three times more likely than children in control communities to be completely immunized by age five (Table 1). SECI children were also more likely to possess a health card and to have received vitamin A supplementation. SECI community mothers breastfed their infants during the first hour post-partum and added oil to their children's food more frequently than mothers in control communities.

Table 1. Immunisation coverage: Comparing pilot sites with non-intervention sites

SECI children were:	1.7 x more likely to have 2.0 x more likely to have 2.2 x more likely to have 1.6 x more likely to have 2.0 x more likely to have 2.2 x more likely to have 1.8 x more likely to have 3.4 x more likely to be	Oral polio vaccine- 1 st dose Oral polio vaccine- 2 nd dose Oral polio vaccine- 3 rd dose DPT – 1 st dose DPT – 2 nd dose DPT – 3 rd dose Measles vaccine Completely vaccinated
Total number of children in study: 342		P value \leq 0.05

In the ten pilot communities, a total of 2334 people participated in regular monthly community meetings that included SECI health presentations. SECI meetings stimulated joint community and service provider dialogue and action that led to a number of significant achievements to improve health services. Some examples of these achievements include:

- Communities and service providers acting together leveraged more financial resources from the municipal health budget for health services.
- In Tarucamarca community, community members expressed their concern to hospital staff that in spite of mass media promotion of the new national health insurance benefits that announced that services for children under five and pregnant women were now free, the hospital continued to charge for consultations. The district nurse explained that the hospital felt obligated to charge for the services because the mayor of the municipality had not reimbursed the hospital for its costs over the last eight months. Community leaders met with the mayor to insist that he pay what was owed to the hospital. The mayor reimbursed the hospital what was owed and services are now covered by municipal funds as per the national policy.

- In Huayllamarca, in a SECI meeting, community members lamented the poor conditions in the hospital. Save the Children/Bolivia offered to assist with \$2,000 to upgrade the hospital on the condition that the community work with the mayor to contribute also. Community pressure to fund this activity led to inclusion of a line item in the Municipal Operational Plan for \$6,000 to upgrade health services. The hospital and community are now making the improvements and the mayor's office is disbursing the funds.

Since the June 1999 evaluation study, coverage rates have continued to improve in SECI communities. SC staff noted that institutional births are also rising. In 2000, district health providers formally acknowledged the health promoters' contributions to community health by offering to them and their families free health care services while they remain active health promoters. SC has expanded the SECI methodology to an entire municipality and will be initiating SECI in two additional districts in February 2001. SCF staff conducted a four-day training program for PLAN International staff. PLAN initiated pilot SECI work in Tarija, Bolivia in 2000.

Lessons Learned

- It was possible to develop culturally-appropriate, comprehensible, and appealing health presentation materials through participatory formative research. To maintain interest, participants require increasingly sophisticated presentations (such as new indicators, graphs and charts) as citizens' analytical skills grow.
- It is critical to share effective solutions with communities to local MCH problems made evident by the health data. For example, families appreciated information about nutrition and preparation of local foods after learning of high malnutrition rates in the communities.
- Dedicated volunteer health promoters were essential to disseminate new health concepts and practices throughout their community and helped to bridge social, cultural, language and ideological gaps that existed between the community and health personnel.
- Promoters were accepted and appreciated by communities and health personnel. Despite the demands placed upon the promoters, most communities decided that their promoters should collect the health data and prepare presentations every month. Generally participants wanted promoters to have more training, practical skills, and education materials. To maintain their motivation, these volunteers will need continued community recognition, positive feedback, ongoing educational opportunities, fair remuneration and supportive supervision.
- Better communication and improved relationships developed between SECI communities and health personnel as community women became less fearful to speak with doctors, citizens began to develop trust in the health staff, and health professionals gained an understanding of the communities' culture and living situation. District health administrators must ensure that new

personnel receive training to maintain partnerships with SECI communities. Health personnel who are unwilling to be involved may need to know more about the benefits and challenges of citizen participation in health service decision-making and learn facilitation skills to make them more comfortable working with communities.

- Although participants expressed satisfaction that health-related decisions were made by consensus, these decisions put considerable pressure on community members to comply. The issue of individual freedom versus the public good may be interpreted very differently in other cultures, and merits further investigation.
- Community characteristics and a supportive policy environment appeared to contribute to the positive outcomes of the SECI project. Communities were relatively culturally homogenous, with established community organizations and traditions of consensus-based decision-making and preferences for cohesive action. Recent government policies promoted community participation (Law of Popular Participation, district health councils), local health planning (decentralization with health budgets for program activities controlled by municipalities), and access to health services (Basic MCH Insurance).
- SC and field workers also supported the project by coordinating and supporting communities, promoters and personnel to come together, and transporting health personnel to the more remote communities for meetings or outreach care when the communities invited them to visit.
- SECI communities could benefit from training in a broader array of social and political action strategies to enhance their advocacy efforts.
- The SECI strategy should incorporate additional measures to strengthen women's participation. Communities holding health presentations during large, male-oriented general community meetings improved women's access to the health information by forming separate health education groups for them. Facilitators of the Warmi project in Bolivia found that dividing participants into small same-sex groups enabled women to participate more fully in discussions and strategy development.
- Sustainability of the CB-HIS will depend on maintaining community interest, as well as promoter motivation and health personnel participation. The collective commitment to participation expressed by SECI communities will be critical, as the time and motivation of individuals are limited and challenged by cultural, social, economic and political barriers that enforce the status quo. These communities must maintain widespread interest in and value for the health information, meet regularly, insist on complete data collection and promoter home visits, and provide the necessary moral and financial support to their volunteer promoters.

Conclusions and Analysis of Community IMCI Implementation Options Framework

The results of this Bolivian experience suggest that a carefully-designed health information system shared by communities and local health personnel increased awareness of health problems, promoted health, and supported community participation in making local health services more responsive and accountable. Community-professional partnerships are feasible with supportive policies in place, and have the benefit of increasing the self-sufficiency of communities and the local health system in sustainable ways. Moreover, this approach was associated with the adoption of positive health practices and uptake of child health services within an existing government framework in less than one year of implementation.

Respectful dialogue between service providers and communities allows them to share power and resources for mutual benefit. The efforts of service providers and communities are better supported when they work together. Service providers who, in the past, recognized the weaknesses in the health system but felt powerless to change the system on their own particularly appreciate a teamwork approach. Partnership and accountability developed through communicating preferences, goals and objectives, and sharing information and responsibility.

A working hypothesis for SECI is that changes made through participatory processes are more sustainable because both providers and communities can see results and have a vested interest in, and a role to play in achieving them. We must document the processes and impact of this program as it matures and expands, paying particular attention to the costs and benefits to the community and service providers and the potential for sustainability, replication, and adaptation on a larger scale. Communities from a wide range of settings should be offered the opportunity to use and modify this new CB-HIS approach to further determine its merit.

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Strategies to Mobilize Communities: The Use of PLA and Other Key Tools to Mobilize Communities and Their Partners in Bergville, RSA

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Reaching Communities for Child Health Workshop

South Africa's democratic election in April 1994 was widely acclaimed as a marvel of our time. Since the election, the once-feared threat of right-wing violence has faded as most conservative Afrikaners accept the new government. The new government is working hard to put its agenda for black social and economic uplift into place, called the Reconstruction and Development Program. Health is one of its major building blocks.

The nation then embarked on a new course to close the gaps for more equitable distribution and access to quality health services. It is incorporating deep shifts in organization, planning, implementation and continuous monitoring and evaluation that seek to bring New South African Health policies to communities and households that have been previously deprived. The District is the focal point for this Health Sector Reform initiative.

Starting in late 1995, World Vision engaged the DOH staff in Bergville District in a collaborative USAID-supported Child Survival project to reduce maternal, infant and child morbidity and mortality in the district by supporting them in the establishment of a decentralized district health structure. Primary health care undergirded by strong community participation was the priority strategy. The emphasis was placed on improving the quality of care and fostering sustainable partnerships between communities, the health system, and local NGOs for the delivery of effective Child Survival interventions.

The Bergville Setting

The health and development situation in Kwazulu-Natal is among the most challenging in South Africa. Over 21% of the population of South Africa live in the Province of Kwazulu-Natal with 62% of the people living in rural areas. It is estimated that over 40% of the households and almost 56% of the children live in poverty. A household survey carried out in 1995 indicates that 52.6% of the population do not have running water on their property; 56% lack access to the public electrical supply, and 35% must travel for one or more hours to access basic health services. Primary health care services were fragmented, inefficient, and did not reach the most disadvantaged or those most in need.

The inequities affecting the Bergville population include: lack of private ownership of land, insufficient infrastructure and job opportunities, and non-existent technical or university education resulting in many young people leaving the area in search of jobs and educational opportunities. The mean household income is below subsistence level and is derived primarily from the remittance monies of migrant workers, agricultural production, and pensions. According to a Knowledge, Practice and Coverage (KPC) survey conducted in 1996, the literacy rate among mothers with at least primary school level is 70%; their access to fuel, transportation, communications and health services is inadequate.

The previous apartheid policies resulted in health services that were fragmented into five separate authorities. These included: National, Provincial, Homeland, Municipal, and private (physicians and traditional healers). All had separate budgets, records, logistics and management information systems. The former system was biased toward curative care, the private sector, with little emphasis on the achievement and maintenance of health for the majority of the population. Except for the private practitioners and the Municipal, three of the five systems have meshed. Salaries have been determined at the National level and paid from the Provincial level. Finally, roles and job descriptions have begun to be redefined consistent with the new primary health care approach.

The advent of the new era of democracy stimulated: 1) the publication of A National Program of Action for Children in South Africa by National Children's Rights Committee/UNICEF, 2) the development of a proposed National Health Plan 3) and the appointment of a National Nutrition Committee that have placed the needs of children as paramount throughout the government's programs of health reconstruction and development. It is within this context that the Bergville Child Survival Project proposal was developed and submitted to USAID by World Vision US for funding in late 1995.

Community Structures

THE BERGVILLE DISTRICT HEALTH FORUM AND COMMUNITY HEALTH COMMITTEES

Development in the health sector in South Africa has occurred in slow incremental steps. In anticipation of the need for infrastructure at the district level, the Bergville District Health Forum (BDHF) was established in 1994. It is an umbrella body of the 60 Community Health Committees which supervise the work of the 65 CHWs. Those involved in its conceptualization were the District Medical Officer, the District Primary Health Coordinator, private practitioners, church groups, Project for the Disabled and other interest groups. The motivation was to have a structure in place based on the National Health Plan in anticipation of future government sanction and funding. The context was informal and approximately one hundred people from a broad base within the community came to the first meeting.

The Forum, comprised of community representatives provides community input into the restructuring of the health services and the development of the District health system. Representatives of the District Health Office serve as resource persons and in an advisory capacity. The Forum will expand to link with any structure that exists in the community that may have an influence on health, such as the Environmental and Primary Health Care Committees. Regular meetings were held four times a year with the

Executive Board meeting on a monthly basis.

The goal of the Bergville District Health Forum was to create a platform for community representatives and service organizations to meet for planning and problem solving on health and development issues related to effective PHC services

The Bergville District Health Forum has matured together with the established Bergville District Development Forum and functions as its task force on matters related to health. In consultation with the District Health Department the Forum helped to establish the Hospital Board, to decide the location of a new clinic and ambulance service. The Forum has helped to focus the participatory learning and action methods that integrate communities into the health development process, starting with the most distant communities first. As the new health areas have been established, it entered into joint discussions with government on the development of the District Health Plan. Furthermore, the BDHF has provided consultation in the development of Community Health Committees for the monitoring of the work of CHW's, and assists in the organization of Community Health Days. All these activities have helped move the Forum to become a major developmental force in the District.

Linked to the BDHF are the four new Area Health Forums that are made up of representatives from the community health committees. This whole network of community involvement is beginning to mean something to ordinary people, not least in their awareness of the value of health care, of inter-sectoral networking with the authorities responsible for roads, water, agriculture, education and so on.

The Bergville Child Survival Project

Upon hearing about the opportunity to participate in the USAID-funded Child Survival grant program, discussions between WV/South Africa and health staff of WVUS in Washington, DC resulted in the collaborative preparation of a proposal in late 1994. In early 1995, USAID awarded WVUS a four-year grant to improve the technical and management capacity of the Kwazulu-Natal Department of Health and the Bergville District Health Forum.

From the very beginning, the project depended for the majority of its activities on Department of Health personnel, supplemented by community health workers (CHWs) who have begun to be absorbed by the Department of Health. Project strategies are directed at health services restructuring including quality assurance tools, community involvement, development of a District-based Health Management Information System and networking linkages. (Figure 1 provides a detailed overview.) These Child Survival initiatives have been integrated into the functions of the District health services with support from the community.

Description of the Paradigm Shift

Starting from the elections in 1994, a wave of change has begun to sweep over all sectors in South Africa beginning with national level policies. The heightened expectations throughout the land have resulted in new tensions and pressures for change quickly, even before all the preparations can be in place. This is true for the health sector as well. The old administrative system was that each hospital administered a network of outlying clinics beneath it and referred problem patients to a larger hospital somewhere above it. The system was essentially curative, the hospitals doing little to encourage clinics to embark on large scale preventive or promotive initiatives. The system also tended to encourage hospitals to enlarge their staffing complements and budgets to cope with the inadequacies of their own clinics.

Valuable Tools in the Paradigm Shift

While the changes and reforms themselves that had occurred is noteworthy, but more importantly, it is key to know what had contributed to making these changes take place. What moved the people to move the system toward a new paradigm? What helped create a spirit of collaboration and enthusiasm to do something different? The answer lies in a mix of considerations of timing and content, individual persons and core groups involved, and internal and external motivations, all transpiring to bring the project to its current status over the course of the past four years. Some of the most significant tools and activities that have contributed to the changes will now be described.

A. GUIDING PRINCIPLES, VISION, MISSION AND CORE VALUES OF THE PROJECT

Shortly after the USAID award of funds, the District Health Management team, the CSP manager and other interested supporters decided that a set of guiding principles, vision, mission statement and core values for the project must be developed. They were purposely designed to be consistent with the National Health Policy directions for development of the district health systems. The Guiding Principles are as listed:

1. Work for and in line with the establishment of a District Health System, within the larger development network of the area.
2. Effect genuine community involvement using a community development approach, where health is seen in the context of total human development.
3. Incorporate learning into the whole process of project implementation. Reflection, quality control, feedback and research will be used to facilitate personal growth.
4. Focus on household and community levels to effect health promotion behavior change, including preventive treatment and appropriate referral beginning with the underserved.

5. Focus on caring, using a person-centered approach in the context of family and community.
6. See every contact as an opportunity for prevention, health education and promotion of continuity of care.
7. Incorporate sustainability in all project components.
8. Gather, process and use information in such a way that the community and the Department of Health can understand and respond to health issues and problems.
9. Be “transparent” and accountable to the people of the district through regular reporting and consultations.
10. Maximize the use of local people and resources and appropriate technology.
11. Promote a team management approach in implementing all aspects of the program.

These statements and principles were equally applied to the evolution of the District Health System and in the establishment of the Bergville District Health Forum. On a more essential and fundamental level, the same principles were applied to daily decision-making, team work and staff development.

B. PARTICIPATORY LEARNING AND ACTION

The Participatory Learning and Action (PLA) method was the strategy chosen to integrate communities into the health development process in the belief that the rural poor have a capacity to inform, learn and implement change. It is consistent with one of the key elements of the proposed National Health Plan, “to foster community participation across the health sector.” The PLA moves from community appraisal and research to development, action and implementation. Secondly, the learning empowers the rural people to carry out exercises and to present the information themselves. Literally, the Bergville District health workers handed over the “stick” (of authority) to the community for them to lead the process. Lastly, unless one participates in the PLA process, it is impossible to have full knowledge of the community situation.

The PLA process was conducted in many of the 60 communities. The supervisor of one PLA team, a nurse who had practiced in Bergville for over twenty-five years remarked, “It is only now through the PLA that I am getting to know the communities in my home district for the first time.” The teams met with community members in their village/community to conduct exercises resulting in: (1) a general map of the village, (2) identification of the health problems of women, children, youth and the disabled, (3) assessment of organizations existing in the village, (4) identification and use of local health care resources to address identified problems, (5) determination of sources of income, (6) selection of a Community Health Committee and Community Health Worker.

At the end of the two-day PLA, a DOH nursing supervisor remarked, “I have gained respect for the people and their knowledge of their community.” Copies of all the proceedings were presented to the village headman and dates planned for an immunization campaign. Other outcomes of the PLA exercise included requests for Health Education Days on drug abuse, teenage pregnancy and HIV/AIDS. Also health messages drawn from the communities’ own words were designed. Some of the creative health messages were, “Down with the bottle, up with the breast,” “Love is great, but sex can wait,” and, “Too many children, too much responsibility.”

C. KNOWLEDGE, PRACTICE, COVERAGE SURVEY

A Knowledge, Practice and Coverage (KPC) survey was first carried out in the Bergville area in 1996 and its findings were discussed with the DOH and the communities. Some of the major findings were: 31% of mothers with children with diarrhea in the previous two weeks gave less fluids or stopped fluids, 82% of non-pregnant mothers did not want another pregnancy within the next two years, and 93% had heard about AIDS, but many believed in myths about transmission. The KPC findings presented a vivid opportunity to discuss with the communities aspects of maternal and child health, protection against HIV/STDS and resources available for family planning.

The next step was to discuss the purpose and services of the CSP and confirm the community understood it. The CHW program was presented and the community decided a CHW must be “clean, visit them directly in their homes and be respectful of them.” Then the concept of a five-person Community Health Committee was introduced. Its tasks require that members attend the orientation workshops, facilitate the work of the CHWs, maintain their timesheets, compensating them according to the hours worked, be involved in health management decisions based on data collected, and finally, to organize Community Feed-back Days.

D. QUALITY ASSURANCE

Quality Assurance (QA) was introduced into Japanese industry in the 1950’s, but it wasn’t until the 1990’s that it was introduced to the health sector with the potential to improve primary health care and child survival programs. QA’s objective is to maximize the effectiveness and efficiency of current systems. The goals of QA are to foster an environment where everyone is more alert to problems of performance and to opportunities for improvement. It is primarily rehabilitative, rather than blaming and aims to give the fullest possible opportunity for human self-expression and actualization that is innate to everyone. QA is not helpful to determine health priorities in a technical way, but is useful to make sure priorities are done in the right way.

Early in the CSP implementation, two members of the DOH team attended a QA Workshop by Johns Hopkins School of Public Health and found the concepts important and relevant to the work in Bergville. It was determined that as the health services developed and underwent changes, quality of services needed to become a focus. QA then became a key issue in the transformation and development of the Bergville District. A plan was prepared and a QA support team established at Regional and District levels.

The QA activities have addressed multiple issues such as: technical competence, access to services, effectiveness, interpersonal relations, efficiency, continuity safety and amenities. The dimensions of quality provide a useful framework for teams to define and analyze their problems and measure the extent to which standards are met. Tools have been developed or adapted for child survival interventions including EPI, nutrition, CDD, Child Spacing, ARI, and HIV/AIDS/STDS. Management tools were under development for assessing health personnel performance, planning, training, supervision, financial management and logistic support.

A QA Advisory and Support team is in place at the Regional Director's office. The QA approach has been found useful for problem-solving at Regional meetings and was used as the framework for the CSP's Mid-term evaluation. Today there is heightened the awareness of quality issues in many activities in the district and other districts have taken up the QA concepts. Also the Bergville District has served as a resource center with linkages to the national director for QA and to the World Health Organization's Collaborating Center for Quality Assurance.

E. TRANSFORMATIONAL LEADERSHIP

Undoubtedly the most radical and innovative input into the Bergville District team's strategic thinking, including the CSP members, came from training in Transformational Leadership (TL), a new concept currently in vogue in the business sector. It borrows its concepts from the Harvard Business School Press publication, "Translating Strategy into Action: The Balanced Scorecard" by Kaplan and Norton and has significantly contributed to a new operating environment for the staff. Such concepts as "management from the future" and "shifting health workers away from the idea of serving the health organization to serving the client", have resulted in a new paradigm and vision that has unified all the partners with a common vision.

The TL concepts are meant to breakdown rigid patterns of organizational behavior and allows for new dynamism based on the conviction that if you work towards a specific vision of the future, you can solve any problem. If serving the client rather than the system is the new emphasis, it makes sense that the clients must have more say. This brings then the possibility that the real goal of district health is a kind of joint management or democratization of health care. The District will soon run a pilot where governance of the health system, including budgeting and planning within the parameters set by a core package of services and staff complements, will be shared district health staffs and the communities they serve.

Of particular interest is how TL became introduced into the District. The former Minister of Health, Mrs. Zuma, encountered the concepts on a study tour in the UK and invited a team from Southmead University to bring them to the health transformation exercises in South Africa. At that point in time, the DOH changes were somewhat stalemated and QA merely addressed problems in the system; it did not open the door to re-framing the entire system in a new way. Beginning in early 1999, over a three month period, more than 40 DOH and CSP staff have received training and mentoring input from the Southmead staff in short 2-3 day spurts. Hospital staff was also included since it was a joint DOH-CSP sponsored training. This core

group of trainees has definitely impacted the system with the TL concepts.

Some of the concepts are: Transformation is a journey; You empower yourself; no one gives you power. People who give you power can take it away. Ordinary people doing extraordinary things; ownership responsibility resides with you. The Culture of Transformation includes: Gentleness, Quality, Unity, Harmony, Discipline.

TL acknowledges the need for:

- Vision-the “seed” (that keeps you connected, unites people, gives direction, the picture of how things can be),
- Mission- the “trunk of the tree” (it unites people around a common purpose),
- Core Values- the “tree in foliage” (they create shared values, something future-based, call for sacrifice, and must be internalized before they can be lived out).

Results to Date

As in any vital system, change in one area brings repercussions throughout the entire system. But when the shifts come in the form of future-based transformational approach, the results go deep and wide. What has taken place is far from finished when planning continues from a future perspective, rather than constrained by problems from the past. People in management, clinical work, and in communities and collaborating NGOs are all involved in co-designing, implementing, monitoring and evaluating the plans and progress. All of these shifts are carefully documented in the District’s recent award-winning application for the National competition; a few of them are summarized here:

- The health care approach now is client/community focussed. Through this process, the community has mobilized to form a functional and active District Health Forum that has been involved in policy making, staff appointments, identification of areas in which to phase in the program, and drawing up operating documents for the program such as the detailed implementation plan. All players in the previously separate sections of the combined MOH have been brought together on the neutral ground of the CSP program to focus on and plan for the district as a whole. The hospital, clinics and mobile staff have people involved as technical trainers, coordinators, and as regular participants in the program planning. All are involved in the training for improvement of technical and management skills of the DOH staff.
- Provincial and regional directors from DOH have shown great interest in the program, have requested presentations, attended and sent senior regional health officials to training workshops and as a result have supported the program and are enthusiastic about the potential ripple effects in other districts. This has resulted in a transfer of lessons learned to other districts.

- Participation in the disciplined process of writing the CSP proposal, doing the baseline study, setting objectives and indicators, and planning interventions has improved management and planning on other aspects of health services. Local people have been given opportunities to develop, use and improve skills and training in a variety of areas and enlarged the pool of technically competent personnel available to the Ministry of Health
- The major childhood and maternal health problems are being addressed. From the client perspective, the introduction of the comprehensive (one-stop) service has been most welcomed. All services are open at least five days a week with the health centers and hospital open 24 hours a day. Previously fragmented service programs (EPI, TB, family planning, nutrition) are no longer vertically run, but share resources, cross-referrals, etc.

THE BALANCED SCORECARD- looks at the tree from a multi-dimensional perspective (MOVE sequentially from BOX I through IV):

<p><u>IV</u></p> <p><u>Adequacy of budget; cost recovery issues; client/provider comments; inventory of supplies</u></p> <p>FINANCIAL – THE LAST ITEM TO BE CONSIDERED</p>	<p><u>II</u></p> <p><u>To satisfy our clients, what processes /services must we excel in?</u></p> <p>SYSTEMS/PROCESSES NEEDED; NEW COMPETENCIES IDENTIFIED</p>
<p><u>I</u></p> <p><u>Clarifying the Vision</u></p> <p>THE CLIENT- ALWAYS START FROM HERE; THE CLIENT IS ALWAYS KING</p>	<p><u>III</u></p> <p><u>What partnerships and collaborations are called for; what new services/technology needed; operational research issues; cost/benefit analysis</u></p> <p>HUMAN RESOURCES –ALL TO SHARE THE CORE VALUES</p>

- The community health worker program is to be expanded and extended. Project surveys and evaluations can provide data to provincial and national policy makers on which to base long-term decisions about CHW programs. They serve as the link to the HIS by monitoring all data from the home-based growth monitoring program. They stage monthly Community Health Days to address needed health education topics.
- The program has given the DOH the flexibility to develop health policy through community engagement, documenting, experimenting and setting precedents while the bureaucracy catches up. Already plans for increased shared governance are underway, moving away further from the old hierarchical “command control” form of leadership to a more “flat-tened” structure that brings health services and clients closer together.
- The program has developed an HIS with the assistance of UNICEF, which has sponsored program personnel in training in HIS development in Namibia. The District HIS, which was nonexistent previous to the program, relates to and contributes data to the provincial and national HIS, as well as providing feedback to the communities.
- Personnel in this program have benefited from interchange with and attention from the international health community, opportunities to network internationally and with other PVOs and institutions, and visit programs and attend courses in other programs and countries. The increase in contact with the international community is particularly important to a South African program, where implementers are coming from years of separation from the international community. The program has established contacts and learned from other African programs in Malawi, Namibia, Eritrea and Mozambique; from US institutions like Johns Hopkins, and World Vision Relief and Development, and to international organizations like UNICEF and WHO. UNICEF-sponsored operational research is on-going in community-based IMCI message development.
- The program has achieved high visibility. UNICEF is working closely with the nutrition program and the program has attracted the attention of the Duchess of Kent, the Zulu King, Minister of Health, Provincial Premier and University principals. Such recognition gives staff and Health Department great incentive to continue their commitment. Project participants are striving for the integration of the program into the Department of Health and facilitating the transformation of health services under the democratic government. The flexibility the program gives has helped this district be one of those leading the transformation process.
- Training programs are now selected after assessment of the needed competencies in the staff leading to greater job satisfaction and more confident performance by health workers and improved health care delivery.

- The introduction of the Sexuality and Life Skills Motivators in the schools and communities are working well with the Department of Education with sustainable program activities on-going.
- The District budget and finance system is in place with costing per service now accountable. Cash-flow committees meet several times a month to monitor and control expenditures and clinics receive feedback on their expenditures together with clear instructions for approval authority and cost-cutting measures.
- Logistics of drugs are according to the new Essential Drug List and supplies are almost always in place. Stores are now re-located closer to the clinics as the two hospitals have become sub-district pharmacies with regular transport to clinics and health centers several times a week.
- The \$250,000 annual budget for the Child Survival program corresponds to the daily budget for the Durban academic hospital; but its influence is enhanced by the program's flexibility. The project director has proposed at a meeting of provincial medical superintendents, that each provincial district be allocated a like sum under conditions similar to those of the program: obtaining baseline data; planning; community involvement; documentation and evaluation; in order to spread public health care in the province and the country forward.
- Finally, transport is now managed by a District Transport Officer according to a Regional and Provincial Plan; the Transport Officer is responsible to monitor the condition of all the vehicles, their utilization and cost efficiency. All vehicles are now regarded as District resources rather than belonging to one institution or program. Patient transport has been reorganized resulting in improved response times and efficiency.

Saving the Lives of Children with Pneumonia by Linking Health Facilities with the Community in Rural Areas of Peru

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General Aspects of the Project

The ENLACE child survival project began interventions in the provinces of Otuzco and Julcán, in rural northern Peru, in October 1996. The intervention ended in September 2000. The project had the objective of reducing maternal mortality and under-five mortality of children from pneumonia and diarrheal diseases. It was implemented by CARE Peru in partnership with the Ministry of Health (MOH) and the Community Health Promoter Associations (CHPAs) and was funded by CARE International and USAID/BHR/PVC.¹

Target population

The target population included 127,633 inhabitants of 597 poor rural communities of the two provinces. Most of the population has little formal education and low incomes. These rural communities are small (usually with fewer than 65 families) and are widely dispersed among mountains and valleys. For 65 percent of the population, the closest health facility is located at a distance of one to three hours. In emergency situations, most inhabitants are forced to walk or to be transported by stretcher.

Given the high number of unreported deaths in rural areas, maternal-infant mortality rates are unreliable. It is estimated that maternal mortality stands at 83 per 1,000 live births while maternal mortality is 261 per 100,000 live births. Pneumonia is the leading cause of death in children under five.

Existing health services

Otuzco and Julcán provinces belong to MOH Territorial Health Unit No. 8. This health unit's facilities include a small hospital, five health centers and 10 health posts.

Project strategy

From the beginning of the project, CARE Peru worked closely with the MOH to improve community health services and to form and strengthen CHPAs. The project interventions included the prevention and control of diarrheal diseases in children under two; the prevention and control of acute respiratory infections (ARIs) in children of the same age; and the promotion of maternal health among women of reproductive age, including pre-natal and peri-natal care by a trained health professional. Using different information, education and communication methods (IEC), the project worked with the MOH and the CHPAs to educate pregnant women and mothers of children under two years of age. The project also used a

Community-based Health Surveillance System (CBHSS) to ensure that high-risk individuals would be referred to health facilities in a timely manner.

Description of Project Activities

B1. General Project Activities

Originally, the ENLACE Project Implementation Plan included three strategies to reach its objectives: community participation; institutional strengthening of CHPAs and the MOH; and synergy with other CARE Peru projects (MSPP, Water and Sanitation and Project 2000).

Nevertheless, as the ENLACE Project advanced, needs were identified that required innovative strategies. The flexibility of the project permitted the incorporation of suggestions from project staff, health care workers, promoters and the community itself; as well as the development of innovations that were first tested on a small scale and then expanded to the entire project area. These innovations involved the implementation of new organizational structures and strategic alliances that better ensured sustainability.

Strengthening of the Health Promoters Associations (CHPAs)

The CHPAs are institutions that permit community health agents to work in a formal institution that represents them before the public health care system at its different levels (network, micro-network, health facilities) and other community-based organizations, such as local governments and other institutions.

Each micro-network of health care services worked in coordination with a CHPA.² Each CHPA is made up of Health Promoter Committees (HPCs), which bring together all the promoters of a health facility. The number of HPCs in a CHPA depends on the number of health facilities that form the micro-network. The HPC coordinates with the facilities (and sub-district entities) and the CHPAs coordinate with the health micro-networks (and district municipalities).

This strategy permits the planning, implementation and supervision of joint activities between health promoters and health facilities, which include fundraising and MOH support of health promoter needs.

Additionally, a study on the best way to create support groups to promote breast-feeding in communities underscored the importance of women's community groups (support groups) in providing information and support to other mothers. This finding led to the development of the "women leaders" strategy in the project. This strategy resolved the problem of women's resistance to male promoters and promoted the timely identification of pregnant women. Currently, the support groups are progressively forming contacts with CHPAs.

- **Articulation of the MOH health service organization with the CHPAs**

The sectoralization strategy was developed to improve community health service delivery, in coordination with the CHPAs. Sectoralization is the division of the geo-population area

covered by the health facility, according to criteria such as geographic access, number of health facility employees, and population density and dispersion. Each subdivision is referred to as a sector. Each health care worker is responsible for carrying out preventive-promotional activities in his sector to decrease individual, family and community health risks. Workers closely coordinate activities with an executive member of the HPC who works with the local health facility.

- **Development of a community-based health surveillance system (CBHSS)**

A CBHSS is a series of activities coordinated at the level of the community and the peripheral health facility that permit the identification and monitoring of vulnerable populations, the early detection and referral of cases needing out-of-household care (including emergencies) and the periodic household follow-up of treated cases.

CARE Peru, the MOH and the CHPAs jointly implemented a CBHSS for the project. This system comprised: (a) a community-based information system, including periodic population censuses and maps, scheduled monthly household visits by CHPA, monthly reports of health events (including births and deaths) and the identification of vulnerable populations (for example, small children and pregnant women); (b) a community-to-facility patient referral and counter-referral protocol; and (c) a protocol for the emergency evacuation of sick patients, including stretchers, radio transmitters, community participation and family savings schemes.

- **Development of information, education and communication (IEC) activities.**

At the beginning of the project, an assessment was carried out to measure knowledge, attitudes and practices of mothers regarding child diarrhea and pneumonia, safe motherhood and breast-feeding. The studies also identified the population's preferences for receiving health education.

The results of the assessment were used to develop educational materials for mothers. These studies permitted the creation of an appropriate, effective IEC strategy that reflected community preferences. This strategy included the holding of contests for the design of murals and textiles, and compositions of song, poems and plays to transmit health-related messages. These activities incorporated the communities' cultural dynamics, such as feast days, through group games such as tombola and roulette. These games included questions on health issues. People who answered correctly received prizes. Through songs, poems and theatre presentations, health messages were disseminated during different celebrations.

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Promoters and health care workers used local radio stations to broadcast health messages using familiar music with adapted lyrics. The project also used face-to-face communication. This strategy included household visits and group talks with mothers using techniques appropriate for illiterate populations.

- **Training of health facility workers**

The project provided ongoing training to health care workers in the following areas:

- Updating of the diagnosis and treatment of diarrheal illnesses, pneumonia and maternal health care issues.
- Collection and use of information, educational methodology, leadership, management and other specific topics.

B2. Activities Related to the Control of Pneumonia

Initially, the project focused on teaching mothers to recognize danger signs and symptoms of pneumonia. The strategy also included training mothers in the proper household care and support of children with colds and infections of the upper respiratory tract, with an emphasis on avoiding the use of antibiotics without a prescription. The information on the early identification and treatment of ARIs and pneumonia was clearly described in the flipcharts promoters used in group talks and household visits.

The CBHSS motivated promoters to provide information to mothers regarding the recognition of danger signs and symptoms of pneumonia, and the importance of immediately advising the promoter to seek medical attention when needed.

The project promoted the immediate evacuation to a health facility of children with signs or symptoms of lower respiratory tract infections or pneumonia. The community participation achieved by the HPCs/CHPAs and the support groups, in coordination with the health facilities, contributed to the development of a system to evacuate children with suspected pneumonia (and other seriously ill individuals).

Initially, the project proposed to the MOH that the promoters administer the first dose of cotrimoxazole in the home before referring the pneumonia case to a health facility. However, the MOH only permitted promoters to administer cotrimoxazole in communities located far from the health facility and only after they had received extensive training and supervision.

² A micro-network is part of a health service network. It brings together a group of health facilities whose communities have an ongoing commercial and sociocultural exchange. The micro-network generally covers the district.

Project Results

This paper will concentrate on the results referring to the control of pneumonia in children under five. The project also worked to prevent and control diarrhea (including the promotion of breast-feeding) and to improve maternal health; however, these areas will not be addressed here.

The project results for the control of childhood pneumonia came from two sources:

- Knowledge, practices and coverage (KPC) surveys carried out in December 1996 (baseline) and August 2000 (final evaluation survey). Both surveys were designed and carried out using methodology developed by Johns Hopkins University for child survival projects implemented by private volunteer organizations (PVOs) with USAID/BHR/PVC funding. During the final evaluation, a KPC sample survey was also carried out in rural communities of Sánchez Carrión Province. These communities are geographically and socially similar to the Otuzco-Julcán communities in the project intervention area and can serve as a control group to measure project impact.
- Review of the service production statistics and sanitary results of the Otuzco-Julcán network for the 1995-2000 period.

C1. Results of the KPC Survey

The table below summarizes the results regarding pneumonia control in the three KPC surveys: baseline (1996), final evaluation (2000) and control group (2000).

A comparison of the three KPC survey results demonstrates that:

- The number of cases of IRA and pneumonia reported by mothers increased, possibly due to seasonal factors.
- The project had significant impact on mothers' increased knowledge of pneumonia danger signs.
- The project had a significant impact on the increased number of children with suspected pneumonia that were treated at a health facility.

C2. Service Production Statistics and Sanitary Conditions in Children under Five in the Otuzco-Julcán Network (1995-2000)

The table and graph that follow show some statistics related to the control of pneumonia in children under five. The MOH Regional Health Office provided these statistics for the years 1995 and 2000.

A comparison of the 1995 and 2000 results suggests that:

- Reporting of ARI cases to health facilities progressively increased, as had the reported cases of pneumonia in the first years. This reporting later diminished, possibly due to families' increased knowledge and the activity of the CBHSS.

- An improved monitoring of cases treated at the facilities, thanks to the coordinated efforts of promoters (in HPCs and CHPAs).
- A decrease in mortality caused by pneumonia, possibly due to the early treatment and prevention of complications in patients with pneumonia.

Lessons Learned

The lessons learned from the pneumonia component refer to the importance of the following EN-LACE strategies:

Focus IEC activities on the assessment and early referral of children with pneumonia using materials and methods appropriate for the target audience (for example, flipcharts to educate mothers during household visits).

- To adequately design the messages and dissemination methods, audience research studies should be carried out in coordination with local universities.
- The most important festivities in each community should be identified for the incorporation of mass health education activities using games such as roulette, tombola, etc. Likewise, theatre, music and poems with health messages can be created specifically for these occasions.
- Health promoters and MOH workers should explore mass media options such as local radio and television stations to broadcast educational programs.
- The educational materials should focus on identifying danger signs of pneumonia such as: flaring of the nostrils, inter and sub-crepitant rales, decreased appetite, etc. It is also essential to develop a training plan for MOH staff and health promoters regarding adult teaching methodologies.

Develop a community-based system to verify the acquisition and adequate use of knowledge and to monitor family health conditions.

- The activities of the CBHSS should establish a close relationship between health promoters and mothers and families of children based on education and information activities. These actions must be oriented to assuring that mothers acquire the knowledge transmitted, as well as adopt adequate practices when their children suffer from ARIs.
- The health promoter should prepare a community map to identify all households with children under two, among other data useful to the health facility. In the households, the health promoter should monitor mothers and families.

- After identifying all households with children under two, the promoter should make a schedule of monthly visits that permits him to continually monitor the health conditions of children in the community.

Develop a referral and counter-referral system for the timely referral and community monitoring of patients previously treated at health facilities.

- The referral and counter-referral card for patients should contain illustrations for easy use by community health promoters. This instrument can consist of three cards: one for promoter monitoring, the second for control by the health facility and the third for counter-referrals. This last card should include instructions for the mother and the promoter to care for the patient in the community.
- At the level of the health facility, a program of at least two visits (during the first 48 hours) should be scheduled to households with children who have been treated for pneumonia. These visits should take place jointly with the health promoter to guide community monitoring actions. This activity should be monitored pictorially in a specially adapted room at the health facility (situation room).

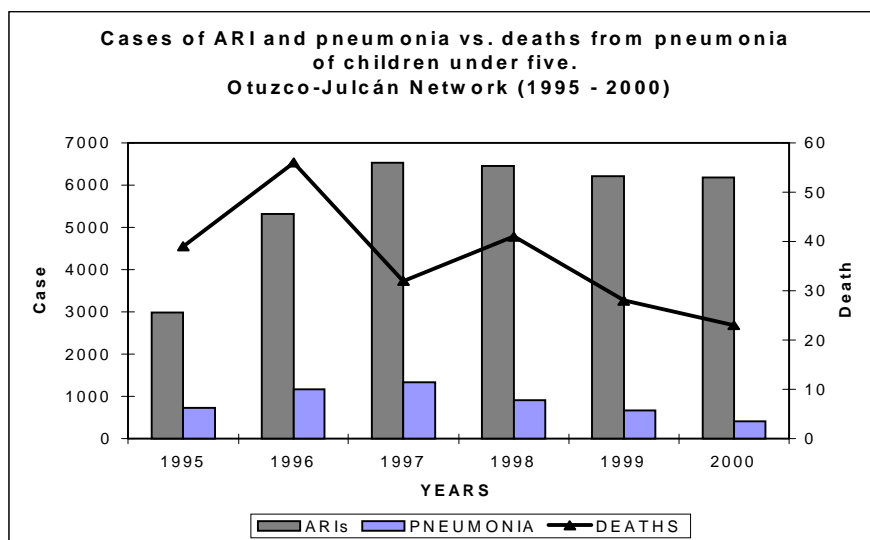
Indicator	Baseline (Otuzco, Julcán, 1996)	Final evaluation (Otuzco, Julcán, 2000)	Control group (Sánchez Carrión, 2000)
Two-week prevalence of acute respiratory infections in children under two.	41.2%	52.0%	56.2%
Percentage of mothers who recognized two danger signs of suspected pneumonia ³	18.7%	56.0%	30.5%
Percentage of mothers who sought professional help for their children with suspected pneumonia	32.0%	60.0%	39.0%

³ The final evaluation revealed that 62.5% of mothers mentioned difficult breathing as a danger sign, as compared with 17% of mothers who identified this sign in the baseline study. Depression of the chest, another danger sign, was mentioned by 32.1% of the mothers surveyed, as compared with 0.6% who mentioned this sign in the baseline study. The proportion of mothers who could not recognize any ARI danger sign decreased from 47% in the baseline study to 20% at the end of the project.

Establish successful working relations between promoters and health care workers to permit the timely referral and treatment of cases.

- Health promoters should participate in community health programs from their inception.
- Health promoters should actively participate in project activities, from the programming to the evaluation of the results obtained. It is necessary to involve them in reviewing both achievements and difficulties, for the joint creation of strategies adapted to the local reality. Only by understanding the what, how and why of the planned activities can health promoters participate actively and therefore ensure the success of the program.

Indicator	1995	2000
All ARI cases reported to health facilities	2,983	5,781
Pneumonia cases (reported to health facilities)	733	407
Pneumonia deaths	39	23
% of pneumonia cases with follow-up visit at 48 hours	40.3%	80.9%



Source: Statistics Office of the MOH La Libertad Regional Health Office

Analysis of the Options for Implementing the Integrated Management of Childhood Illnesses (IMCI)

The ENLACE Project has served as an important lesson for the child survival projects that CARE implements around the world. The General Epidemiology Office of the MOH has requested that CARE Peru replicate some project strategies (for example, the CBHSS) in different regions around the country.

The most significant contributions of this project to the IMCI model include the following:

- The design and validation of effective organizational structures — CHPAs and HPCs — to support and sustain the work of community volunteer health promoters and to successfully link them to the formal health system.
- The development of a CBHSS that links the community with the public health system.
- The technical focus in the intervention was highly effective due to its orientation to best practices, with strategies based on the analysis of mothers' beliefs and practices. It emphasized the identification of danger signs and symptoms by promoters, the referral or evacuation of patients to health care facilities and the organization of household visits by health care workers.
- The use of local technical resources to implement field research and to satisfy technical assistance needs. Study results were used to design health communication messages in accordance with community resources and preferences.

The ENLACE Project confirmed that the organizational and administrative aspects of a community health program are at least if not more important than its technical aspects.

Partnerships to Increase Access, Quality and Scale of Childhood Pneumonia Treatment through Female Community Health Volunteers

Penny Dawson, MD

John Snow, Inc.

In collaboration with ADRA, CARE, PLAN, Save the Children (US) and the CDD/ARI Section, Ministry of Health, HMG/Nepal

Overview of Background and Establishment of Program

Setting

Under-five mortality in Nepal remains high, at approximately 100 deaths per 1,000 live births, and as in other high mortality settings, pneumonia is a leading cause of childhood death. However, Nepal is an exceptional example of donor/MOH/NGO partnership on a large scale to reduce childhood deaths through case management at the community-level. Nepal's CB-IMCI initiative has grown out of experience with community-based treatment of pneumonia over the last sixteen years. The combination of the IMCI approach, with the successful experience in Nepal of working with Female Community Health Volunteers¹ to treat pneumonia, dehydration, and provide other services, is unique.

Background

Starting in 1984 with a small study in the Kathmandu Valley,² controlled intervention trials and pilot projects in three districts of Nepal demonstrated that case management of pneumonia through Community Health Workers (CHWs) was feasible, and that this approach could substantially reduce under-five mortality, consistent with findings from several other studies reported by WHO and others.^{3, 4} During the Jumla ARI Intervention Trial in Nepal's northwestern mountains, CHWs detected and treated 850 cases of pneumonia per 1,000 children per year in a very high mortality setting.⁵

The controlled study in Jumla documented a 28% reduction in all-cause under-five mortality in an area with very poor access to all other child health services. In a lower mortality setting in Dang District in the plains of Nepal, CHWs treated 450 cases of pneumonia per 1,000 children per year. Based on this experience, the REACH (Resources for Child Health) Project estimated a nation-wide incidence of childhood pneumonia of between 300 and 500 cases per 1,000 children per year.

In 1993, even using the lowest estimate of pneumonia incidence, it was calculated that overall only about 15% of expected pneumonia cases were being brought by caretakers to the government health facilities for assessment and care. Therefore, relying on caretakers to bring sick children to fixed facilities would not be adequate to save lives. Treatment needed to be taken closer to the children's homes, as had been done in the three pilot projects. However, these three projects were implemented through NGOs, functioned independently of the MOH system, employed literate CHWs, and were able to provide supervisory and

other external supports. The challenge was to develop, implement, and sustain an effective intervention through the MOH system.

Establishment of the ARI Strengthening Program

In 1993, the MOH, USAID, JSI, UNICEF, and WHO formed a working group to develop an approach, then referred to as the ARI Strengthening Program, which would bring much needed pneumonia diagnosis and treatment through the MOH system closer to children. The establishment of a National ARI Policy in 1994 assisted the development of an implementation strategy. Preparation and production of training and IEC materials were completed in early 1995.

The overall objective of the program was to reduce mortality from pneumonia in children under 5 years of age through case detection and timely and appropriate antibiotic treatment. Secondary objectives were:

- To ensure that health workers conducted standard case management of all ARI cases, which present to health facilities.
- To extend appropriate pneumonia case detection and treatment beyond the health facility and into the community through the MOH peripheral health workers: Village Health Workers (VHWs), Maternal and Child Health Workers (MCHWs), and Female Community Health Volunteers (FCHVs).
- To reduce the inappropriate use of antibiotics and cough and cold remedies for the treatment of ARI in children.
- To increase the knowledge of mothers and other child caretakers about how to recognize the signs of pneumonia, when and where to seek help, and to provide supportive home care.

Strategy

The primary strategy was to extend pneumonia case detection beyond the fixed facilities through VHWs, MCHWs, and FCHVs, referred to collectively as Community Health Workers (CHWs). The CHWs were trained to follow the WHO guidelines for standard case management at the community-level,⁶ in which the diagnosis of pneumonia is based on clinical signs, particularly specific respiratory rate cutoffs by age, identification of danger signs, and standard antimicrobial treatment of simple pneumonia in children 2 months to 59 months of age. Cases of severe pneumonia or very severe disease were referred to the nearest health facility with a trained worker.

In-depth Description of “Pilot” Intervention

Initial Intervention Models: Since it was not clear whether or not these CHWs would be able to successfully conduct diagnosis and treatment, and whether or not the supervision would be adequate to support them, it was decided to initiate two different intervention models.

Treatment Model: In two districts, CHWs diagnosed pneumonia using respiratory rates determined by using sounding timers, and if the child had “pneumonia only”, they would treat with the first line antibiotic, cotrimoxazole in pediatric tablet formulation. If chest indrawing or other danger signs were present, they would refer these more seriously ill children to the nearest facility with a trained health worker.

Referral Model: In two other districts, CHWs diagnosed pneumonia using the sounding timer, checked for danger signs, and referred all cases of pneumonia, severe pneumonia, or very severe disease, to the nearest trained health worker.

In both models, the CHWs were advised to re-examine the child on the third day after treatment or referral, and determine if the child was improving or needing further assessment and care. In addition, all the CHWs would give caretakers advice about home therapy, danger signs, and when to seek further help. The antibiotics were provided free of cost at both the community and health facility levels. All the health workers, both health facility and community-based, received their initial training through the ARI Strengthening Program in 1995, and were monitored closely by JSI and MOH staff for the next one to two years.

Methods, Results, Achievements

Monitoring

Monitoring activities were conducted at facility and community-levels. At health facilities service records were reviewed and case management observed. CHWs, primarily FCHVs, were visited at their homes, their knowledge and skills assessed, and their records reviewed. Standardized checklists were utilized for all monitoring activities. On-the-spot correction of any errors was made and positive feedback given. Over 80% of FCHVs retained excellent knowledge of criteria for diagnosis of pneumonia, recalled correctly the doses of cotrimoxazole required for the two different age groups, and counted respiratory rates correctly. Resupply of cotrimoxazole to FCHVs was done at the time of monitoring, either through the regular VHW visits or JSI/MOH visits.

Innovative recording forms for use by illiterate and semi-literate FCHVs were prepared, and record review of treated cases was utilized as an objective method of collecting indicators of program quality. Correct antibiotic dose by age group was monitored, along with the percentage of children receiving third day follow-up visits, and the percentage of cases correctly classified according to the clinical findings. Actual case management was observed where possible.

Assessment

An external assessment was conducted in 1997 with technical assistance from WHO/SEARO and WHO/Geneva, and the findings were very encouraging.⁷ Respiratory rate was assessed in 95% of children, with agreement with surveyors in 81% of cases. Chest indrawing was assessed in 59% of children, with agreement with surveyor’s assessment in 93%. For all cases of ARI assessed, the classification was correct in 81% of cases, and total case management was correct in 80%. Only 2.6% of the children who should

not have received them were given antibiotics by the CHWs. In addition, community-based treatment doubled the percentage of expected pneumonia cases that were identified and appropriately treated.

Cautious expansion of the “treatment” model was recommended, as CHWs, particularly FCHVs, had proven capable of correct pneumonia case management.

Expansion

The original two “referral” districts were converted to “treatment” districts in 1997/98, and two additional districts were added. In 1998/99, five more districts were added in collaboration with four international NGOs working in Nepal (ADRA, CARE, PLAN, and Save the Children/US) to maximize monitoring and support of the Community Health Workers, particularly the FCHVs. At the same time diarrhea, nutrition/ Vitamin A, and immunization were included in the training package, and the Program was renamed the Community-Based ARI/CDD (CBAC) Program. From July 1999, the experience of these previous programs was combined with the Integrated Management of Childhood Illness (IMCI) initiative under the name Community-Based IMCI (CB-IMCI).

The original 11-day IMCI training course for Health Workers at Health Post and Sub-Health Post levels has been revised into a 9 plus 2-day training course. The two additional days cover program management training, which was lacking in the original IMCI approach. The 5-day integrated training package for VHWs and MCHWs has been adapted and translated into Nepali. Two days have been added to reinforce essential recording and reporting skills and guidance on how to function as a supervisor of FCHVs. For the FCHVs, the CBAC course materials are still being used. FCHVs have an initial 5 day training (3 and ½-days of training, ½-day orientation for local leaders, and 1-day mothers’ group orientation) followed by a 2-day training after three to four months. Community leaders and decision-makers are included in orientation meetings to encourage them to further support and strengthen child health activities.

Achievements

To date, through all the Community-Based Child Health Programs, a total of 1,437 health facility staff and 9,311 community health workers, including 8,124 FCHVs, have been trained in the standard case management of pneumonia. Over 114,000 village mothers have been oriented by their FCHVs to the signs of pneumonia, appropriate home care, and when and where to seek help. Thousands of traditional healers, and 301 district-level and 7,524 village-level leaders have been oriented to the community-based child health program and their role in supporting FCHVs and saving children’s lives. IMCI materials have been adapted from the original WHO materials and translated for Nepal. Training, IEC, and reporting materials appropriate for semi-literate village women have been developed and monitoring systems established.

During the past 2 fiscal years, the CB-IMCI initiative has been fully implemented in 3 districts. Community-based treatment of pneumonia is now available in 14 districts, which represent 28% (936985) of all children under 5 in Nepal. Monitoring is ongoing in all districts; NGO staff take an active role in

monitoring CHWs, mainly FCHVs, in 6 of the 14 districts and JSI field staff monitor CHWs in all 14 districts. Partnerships from the early days of planning and policy formulation to the present level of supportive field supervision have allowed the program to expand while maintaining quality.

Results

Not only have community health workers, mainly FCHVs, proven themselves capable of correctly diagnosing and treating pneumonia, but their involvement in the pneumonia control program has greatly increased access to treatment for children. By July 2000, the percentage of expected pneumonia cases receiving treatment in the 4 initial program districts had reached 57% with over half of the cases treated by the FCHVs. The average in non-program districts remained at only 22% of expected pneumonia cases receiving treatment from MOH fixed facilities.

This 2.6 fold increase in children reached, combined with information on the quality of case management, strongly suggests that this program is having a substantial impact on child mortality in Nepal. Using calculations of potential deaths averted based on Pharping Study1, it is estimated that thousands of child deaths are averted annually in the first 13 program districts.

Lessons Learned

Partnerships between the MOH and international NGOs have increased program support and monitoring, and allowed testing of other innovative approaches such as cost recovery, with FCHVs now selling cotrimoxazole in some districts.

Lessons Learned include:

- Importance of working in accordance with the MOH's National Child Health Strategy.
- Commitment of national, district and health facility-level MOH staff is essential.
- FCHVs, if properly trained/followed up and supported can identify and treat pneumonia cases and refer more severe cases of pneumonia.
- NGO/PVO role in supportive supervision of FCHVs is critical for maintaining quality of performance.
- Simple inputs such as timers, cotrimoxazole, and regular support (monthly meetings with FCHVs) can generate continuous interest and remarkable commitment from the volunteers.
- Support from local government and community is necessary for sustainability of FCHVs' activities. Active and early involvement of local leaders and decision makers is important.
- Local support (including financial) can be generated through awareness raising activities and interaction between local leaders, FCHVs and NGO/support organizations. Follow-up is required to maintain commitment and momentum.
- Recognition of important role of FCHVs in life-saving activities can be developed as program matures. Community, health facility and district health personnel develop confidence in FCHVs as program experience grows.

- Community-based program increases treatment rate for children more than twofold in program districts and potentially saves thousands of lives each year.

Areas to be strengthened:

- Mothers' and caretakers' knowledge about danger signs/referral and appropriate home care lags behind FCHV knowledge. Need to develop or strengthen mechanisms to improve communication and transfer of knowledge through Mothers' Group Meetings and other community resources.
- Development of sustainable mechanisms is needed for community support of FCHVs after external support is withdrawn.
- MOH monitoring systems (HMIS) must include community-based treatment records otherwise service provided by FCHVs is "lost" in the national figures.
- Advocacy for FCHVs and community-based programs is still inadequate at high levels in the Ministry of Health. Renewed efforts are needed to keep them informed of program achievements.

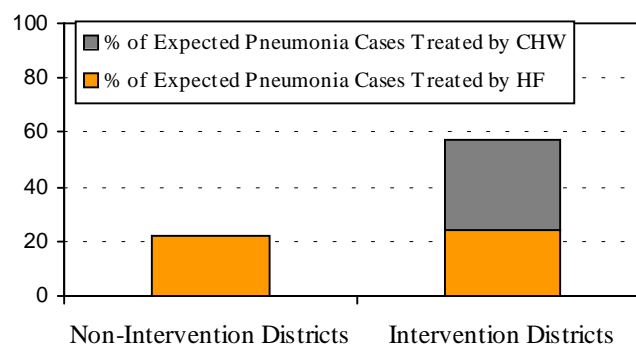
Analysis of Community IMCI Implementation Options Framework

The experience of the community-based treatment of pneumonia in Nepal fits well into **Intervention Option Two: Improved care outside of health facilities**. The skills of community-based health workers have been upgraded and monitored with the assistance of NGOs/PVOs. This has resulted in increased numbers of children with pneumonia being identified and treated and large numbers of children (over 80%) re-examined and followed-up on the third day after initiating treatment at the community-level. More severely ill children are referred to the nearest health facility. Mothers/caretakers receive home care advice and studies suggest that they retain the information given by the FCHVs. Revolving drug funds, largely set up with local community support, are functioning in many districts to ensure year-round availability of cotrimoxazole and ORS.

This program has some overlap with **Intervention Option One: Closer links between health care facilities and communities they serve**. FCHVs who treat pneumonia report to the MOH health facilities and ties are strengthened between them and the fixed facility workers. They help to form a bridge between the community and the HF. The FCHVs educate mothers about the symptoms and signs of illness requiring careseeking from the Health Facilities. HF workers' skills have also been improved as they are involved in trainings and supervision of CHWs.

The cross-cutting activities of the program include: advocacy for resources; support for sustaining a community-based practitioner; and perhaps most importantly, formation of partnerships to increase the scale of the intervention while maintaining the quality. Advocacy for resources occurs at different levels: nationally securing MOH and donor partner support for the program and preparing combined workplans to pool resources to maximize the program benefits; at district and village level seeking commitment of local resources to sustain the program either for indirect incentives for the volunteers, fixed deposits to start revolving drug funds, endorsement of cost-recovery for drugs, etc.

Partnerships have varied over the life of the program. Initially, efforts were largely focused on ensuring that donors (WHO, UNICEF and USAID/JSI) worked closely with the MOH to develop a single program policy and design for implementation based on sound research results. Later, after the “pilot” phase, in order to increase the rate of program expansion while maintaining quality, JSI assisted the MOH to orient¹ Female Community Health Volunteers (FCHVs) are local women, usually married with children, selected by a group of mothers in their communities to receive 15-day basic training from the Ministry of Health and then serve as volunteers to provide health education and some limited services in their own villages. potential partner NGOs to the program and solicit their involvement and support, particularly in the area of FCHV monitoring and supervision. At the present time, services of a qualified local NGO are also being sought to further increase the capacity for expansion to new districts.



Conclusions

Experience gained while implementing the community-based pneumonia treatment program in Nepal has contributed insights into the need and potential for expanding good quality child health services beyond health facilities. From July 1999, the community-based child health program, led by pneumonia treatment through FCHVs, has merged with the IMCI initiative, defining a clear direction for future child health programs in Nepal. Expansion of the PVO/NGO role would allow more rapid expansion of this successful and highly-needed program. Collaboration at multiple levels between many partners, including sharing of scarce resources, has led to an additive and very positive program impact, which could not have been achieved by any one agency alone.

¹ Female Community Health Volunteers (FCHVs) are local women, usually married with children, selected by a group of mothers in their communities to receive 15-day basic training from the Ministry of Health and then serve as volunteers to provide health education and some limited services in their own villages.

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⁶ World Health Organization, Programme for the Control of Acute Respiratory Infections, 1992. Treating Children with a Cough or Difficult Breathing: A Course for Community Health Workers.

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IMCI Leadership through Innovation

Dr. Karen Cuevas

Project HOPE

This paper shares Project HOPE's experience in the Dominican Republic in modifying an IMCI tool to reduce the clinic's recurrent costs. The development of this tool not only resulted in reduced costs, but involved the providers in an in-depth analysis of IMCI and led to improved targeting of home visits for children diagnosed at risk by the IMCI protocol.

Overview of the Project or Activity

Opened in May 1996, the Order of Malta Maternal and Child Clinic is a private clinic established by the Dominican and American Associations of the Order of Malta with technical and financial assistance by Project HOPE. The clinic is located in one of the poorest *barrios* of Santo Domingo and serves pregnant and lactating women and children under five years of age. The clinic charges a fee of 30 pesos (\$1.79) for first visits and 35 pesos \$2.09 for follow-up visits, as well as for drugs and laboratory tests. Within less than three months, the clinic was operating at full capacity and has added additional services over the past years (additional lab tests, ultra-sound, dental). The Order of Malta and HOPE have also created an endowment fund for the clinic which will assure financial sustainability of the clinic by 2002. At that time, interest income from the endowment, plus fees-for-services will completely cover the clinic's expenses. The Department of Health is covering the salaries of eight physicians and three nurses, thereby reducing the recurrent cost of the clinic, however, the management of the clinic is under full control of Project HOPE and the Order of Malta.

From its inception, the clinic integrated lessons-learned from the BHR/PVC child survival program (HOPE's DR Country Director was the CS Coordinator of two prior BHR/PVC-funded CS projects in Ecuador). Without USAID pressures to meet coverage levels, the clinic has focused on 1. providing high quality clinical and preventive services, combined with a community outreach program for broad community education, as well as counseling and home visits for individual families and 2. And achieving long-term independence and financial sustainability. Prior to the introduction of IMCI in the DR, clinic staff were using the most current case management norms for illness such as diarrheas and ARI. Upon arrival at the clinic, staff also checked that each child was up-to-date with respect to immunization coverage, monitored weight gain and counseled the caretaker on child nutrition. The emphasis of the clinic was not on treating isolated child disease episodes, but on promoting well-child visits and continuity in care. Service statistics indicate that return visits make up an important portion of the overall visits to the clinic (for example during the Year 2000, 57% of children with pneumonia were brought back to the clinic for a follow-up visit). This is an indicator of client satisfaction with the services provided, given that clients have the option go to MOH health centers in the neighborhood and receive free care.

The clinic team consists of eleven physicians, six nurses, and seven office clinic assistants. The Outreach team is comprised of a physician Director and three locally trained social workers and health educators. In addition six promoters volunteer a day per week to the community outreach activities. In addition to home visits and follow-up, the community outreach team also conducts health education groups for mothers and

pregnant women; assists the department of Health with immunization campaigns; trains health promoters of other agencies in other zones of Santo Domingo, and conducts operations research. The six promoters currently working with the project were trained in one of the two courses HOPE conducted on community-IMCI and decided to volunteer with HOPE and assist with home visits and other tasks given to them by the community outreach staff.

The high quality of care provided in the clinic is recognized widely locally. The clinic serves as a in-service training site for physician interns and has participated extensively in the national introduction of IMCI through collaboration with PAHO on the development of community health worker materials and as an IMCI operations research site.

Since the clinic's opening through September 2000, over **91,260 patients** have been seen and treated. Other significant accomplishments include:

- 68,709** Pediatric checkups and treatments
- 22,425** Pre and post natal consultations
- 77,211** Immunizations have been given
- 11,000** Mothers have attended health education meetings
- 6,810** Home visits have been made by health promoters
- 2,302** Mothers have participated in weekly Mothers' Groups

Description of the Project HOPE IMCI Tool

The implementation of IMCI in the Dominican Republic brought a number of challenges to the clinic, which is concerned about containing costs in the interest of its long-term sustainability, as explained above. It was clear that

- More time would have to be allocated to the assessment, treatment, and counseling of each individual patient;
- There would be increased expenditures for reproducing the IMCI forms, one per disease episode and storage of additional files; and
- Entering data from the standard IMCI protocols is difficult and time-consuming.

To reduce the cost of copying IMCI forms and to be able to track disease episodes for the many children who return regularly to the clinic for well- and sick-child care, the staff developed a new form (see Attachment 1). This form closely follows the IMCI protocol in content, however changes the way information is coded: All diagnostic information, signs and symptoms, drugs provided, and recommendations is recorded using a coding list. Each provider has a permanent card (see Attachment 2) with a list of all codes. The patient record provides space to record up to 10 disease episodes. Repeat occurrences of the same diseases are immediately visible to the provider who can adjust the treatment, ask more targeted questions of the caretaker, conduct more in-depth counseling, or notify the community outreach staff to conduct a home visit.

Methods, Results, Achievements

1. Development of a New IMCI Form

Before implementing the new form and codes, a one-day workshop for the clinic health team (the physicians, two of the nurses, and two of the community outreach staff) by the Clinic Director and the Director of Community Outreach to analyze the IMCI process of assessment, diagnosis, treatment, and counseling within the overall context of the clinic constraints and existing processes. The staff acknowledged the importance of the content of the original IMCI form, but expressed concern that this form did not allow them to review past case information that might be relevant to the current disease episode. At that point a draft of the new form was presented to the team. Each team member had 48 hours to review and test the new form. In a subsequent meeting the staff proposed some changes to the new form and added some classifications, codes, medications, and procedures. The staff were also concerned that the list of codes was too long and that at least initially it would take too much time to find the right code. This might then interfere with the communication between provider and caretaker.

The changes proposed by the clinic staff were made, and then we began to use the new form concurrently with the original one. For three months, sick children with even case numbers were evaluated and treated with one form and children with odd numbers with the other form. Then the clinic team met again, reviewed the information that had been collected, and reassessed the capacity of the new form to maintain the critical formation about signs, symptoms, and recommendations of the standard IMCI form. The following issues were discussed:

1. Does the new form summarize all symptoms and sign needed to make a correct IMCI assessment?
2. Does the new form facilitate the doctor's work?
3. Does the form reduce cost?
4. Does the form offer a good opportunity to evaluate the same child during different clinic visits?
5. Could this form be used by other clinics or health centers?
6. Does the form keep the IMCI evaluation system intact, i.e., does it help health providers to quickly identify those signs and symptoms that indicate that the child is at high risk of mortality.

The staff concluded that:

1. Children were classified and treated the same way with both forms, keeping the IMCI evaluation system intact;
2. The new form reduced the time providers spent on completing the form. Given that the clinic operates on a cost-recovery principle and has to control the average time spent per patient, this made it more possible for the provider to have the necessary time to counsel the caretaker.
3. Form reproduction cost were reduced, given that the new form is used for up to ten visits.
4. Providers have information about previous sick child visits and can treat the child and advise the caretaker accordingly.

5. This form can be used by other clinics and health centers that use IMCI, if time is allocated to train staff in the new form.

Based on these results, the new form was adopted as the standard. After six months of use of this new form (the last two months with only the new form), additional minor revisions were made, proposed by the providers as the form is continuously tested and evaluated in its daily use.

The form was shared with the DR PAHO team who used and modified this new form. On September 13, 1998, Project HOPE staff presented this form at the National IMCI Conference. The Spanish Agency of Cooperation asked to have two of their staff trained in the use of this new form to reduce the cost of IMCI implementation in the east of the DR.

However, the greatest merit of this new form is its support to community outreach work.

2. Use of the New IMCI Form for Community Follow-Up

As explained earlier, the Malta/HOPE clinic provides two primary services to its target population: clinical and preventive health services at the clinic level and community health education. The Community Education Program conducts health education for mothers and pregnant women, following community-IMCI curricula content and provides community follow-up and home visits to families of children under 5 years of age.

When the clinic was initiated in 1996, the community outreach staff waited for the clinic doctors to recommend home visits for specific families. However, no standard criteria were available to make such a decision. One doctor might decide that an individual child was at risk and needed follow-up, while another doctor would not have suggested follow-up for the same case. The community staff spent much time in reviewing patient charts and selecting those they thought were in great need of a home visit.

Now all physicians classify IMCI conditions in the same way; the community outreach team can take the daily list of cases and provide follow-up in the home; and both staff share common criteria for follow-up and home visits. All children that come to the clinic with IMCI danger signs (e.g., pneumonia, severe malnutrition, etc.) and live in the Barrio de Buenos Aires de Herrera receive a home visit by a member of the community outreach team, an average of about 11 children per day. Following IMCI protocols, children with pneumonia are visited 24 hours after coming to the clinic. Children with other problems identified by the IMCI protocol are visited about midway between the original clinic visit and the scheduled follow-up visit. The form provides information about the child beforehand (e.g., illness history, the child's nutrition, immunization coverage) which assists the staff in counseling the families.

In addition, these children are also monitored by a HOPE trained health promoter. These six promoters have been trained in community IMCI using the PAHO curricula. They assist staff in making home visits and in conducting health education for mothers' groups. During home visits, they make sure that the child recovers, provide information about home management and prevention to the family, and refer the child back to the clinic if necessary.

The impact of this new strategies has been assessed through the Operations Research conducted by the

outreach team every four months. Based on OR findings, caretakers brought 57% of children back to the clinic for the scheduled follow-up visits in 2000 compared to only 38-41% in 1998. Only 2% of the children that came back in the past year had not improved (no data are available for the previous years). Changes in the proportion of clinic visits for the purpose of treating a sick child provide some support to the positive impact of IMCI implementation at the health facility and targeted home visits. Sick child visits have reduced steadily from 84% in 1995, to 76% in 1997, 71% in 1998, and 62% in 1999. In addition, as mentioned earlier, the percent of caretakers that bring the child back for a follow-up visit has increased. The staff are very positive about the value of these targeted home visits to children identified at risk. Clinic physicians, in particular, insist on this service for their patients and sometimes give the community outreach staff specific messages or advice that should be given to a family.

Lessons-Learned

1. Lessons-Learned Related to New Form

- IMCI is a comprehensive package. However, its components (in this case the main protocol) can and should be broken down for further analysis and improvements that lead to greater efficiency and effectiveness, as well as reduced cost for implementation.
- With assistance of the new form for targeting home visits, the providers actually see how children have improved at follow-up visits, and gain the satisfaction that they have successfully resolved a health problem. If the child did not improve, it is more likely that the provider will make a stronger effort to work with the mother on helping the child recover.
- The process of investigation teaches the providers much about the overall IMCI approach and its effectiveness.
- The clinic staff assisted in the development, testing, and implementation of an important innovation. Involving staff in this process also increased their ownership and commitment to using the form appropriately and consistently.
- Interest in HOPE's new IMCI tool by PAHO and other agencies indicate the potential value of this tool to other organizations.

General Lessons-Learned

- The clinic staff thought that IMCI would not require more time per person than good standard case management or that the time needed per patient could be reduced gradually. Good IMCI case management requires about 20 minutes, which affects the number of cases that each provider can see per day. In the case of the HOPE/Malta clinic, this affects the clinic's income and achievement of sustainability.
- IMCI requires substantial changes in the way physicians work. Maybe these changes were introduced too quickly in the Dominican Republic. Even in a very supportive environment with ample supervision, as in our clinic, physicians still do not always comply with the new protocols and approach to treatment which differs completely from what they have learned in medical school (i.e., treat a disease not the whole child).

Field Staff-Centered Management to Improve and Maintain Health Education

Ellen Vor der Bruegge
Freedom from Hunger

What is Freedom from Hunger's *Credit with Education*?

Freedom from Hunger, an international nonprofit organization, has been implementing its *Credit with Education* strategy to improve the nutritional status and food security of women in poor, rural areas of Africa, Latin America and Asia. Working through partnerships with 29 social enterprises¹ in 12 developing countries, *Credit with Education* is helping more than 150,000 women improve their own health and income while improving the welfare of their children.

The program uses a village banking strategy to provide small-scale loans (less than \$300) and adult participatory education to economically active poor women. With improved knowledge of child survival practices and a means of earning their own income, women make the most difference in improving the health of their families. Participants form self-managed Credit Associations (village banks) and guarantee each other's loans used to invest in income-generating activities. Members meet weekly to repay the principal and interest, deposit savings and learn more about basic health and nutrition practices, family planning, and small business management. The health education promotes recommended practices in the following areas: (1) diarrhea prevention and management, (2) breastfeeding, (3) infant and child feeding, (4) immunization, (5) family planning and (6) HIV/AIDS prevention.

Credit with Education Benefit Process

Results of well-documented longitudinal studies using control groups show that participants in Credit with Education programs can increase their incomes, practice the new health behaviors they were taught and improve the nutritional status of their children as measured by height-for-age and weight-for-age scoring systems.

These health and income benefits are created and sustained by the willingness of the women to repay their loans at a very high rate. The long-run loss rate is 0.26% meaning that out of \$63,304,234 lent over the past 10 years, only \$164,591 has been written off as unrecoverable. The portfolio-at-risk is only 3.52% meaning that of the current \$8,168,360 in outstanding loans, only about \$287,526 represents loans that are behind in being paid.

The interest paid on these loans is being used to create sustainable service-delivery institutions that will be able to continue providing Credit with Education services to destitute populations without resorting to grants to cover their operating expenses and financial costs. Of the 29 institutions offering Credit with Education services, 14 are now able to fully cover their expenses from interest revenues. The consolidated financial self-sufficiency ratio for all 29 institutions is 85%.

Of those local social enterprises with which we work, the most promising potential has been with credit unions. They currently account for 65% of Freedom from Hunger's total outreach or over 85,000 women with an average loan per borrower of \$75 and have achieved a relatively higher standard of financial self-sufficiency (79%) than the other organizations with which we work. These numbers are growing.

Description of the Strategy

Freedom from Hunger's innovation and leadership lie mainly in integrating health/nutrition/family planning education into credit and savings networks for very poor women. Our motivation is to provide both resources and information to enable very poor women to overcome chronic hunger and malnutrition for themselves and their families. An adult participatory education curriculum that covers diarrheal disease management and prevention, breastfeeding, infant and child feeding, birth timing and spacing, immunization, and HIV/AIDS prevention and response has been developed. Each of these topics consists of six to eight short, highly interactive and participatory learning sessions. The curriculum topics were built around

Facts for Life: A Communication Challenge, which was developed jointly by UNICEF, WHO, UNESCO and UNFPA. In addition to the health and nutrition topics, Freedom from Hunger has developed learning sessions in better business practices.

These two sets of educational topics are integrated into a curriculum that is delivered on a weekly basis. Each learning session is designed to last no more than one-half hour. What is important to note, however, is not only the list of lessons, but the approach taken to education in general. Three factors incorporated into Freedom from Hunger's approach on educational services have made a big difference in the receptivity of the participants to the program.

The first factor is how one views and tries to motivate behavior change. Working with people (especially adults) to change a belief or practice is a complex process. Often, an individual must take a mental journey that involves a number of steps before making the decision to change ideas or practices and form a new habit. The process (see attachment 1) is illustrated as the *Road to Behavior Change*, showing the steps that can be part of the personal change process and the field agent's role in facilitating the process.

The second factor incorporated into Freedom from Hunger's approach looks at ways to lead a learning experience. This is a four-step process called Observe, Reflect, Personalize and Act (ORPA) which field agents are trained to use when working with Credit Association members. It helps the field agent, as facilitator, set up a learning process whereby participants learn to "observe" (what happened in the presentation?), "reflect" (why did it happen [cause], what are the results [consequences]?), "personalize" (how does this apply to us?) and "act" (what action are we going to consider?).

The third factor incorporated into Freedom from Hunger's approach is the sequence of the topics themselves and of the learning sessions. There is a logical basis for the recommended sequence of learning sessions. This is especially true for Health/Nutrition/Family Planning topics.

On the economic side, Freedom from Hunger moved away from a diversified portfolio of coopera-

tive income-generating projects to a minimalist microfinance strategy largely because a minimalist strategy was less expensive and more successful. The strategy also proved more sustainable in terms of being able to generate the resources necessary to cover costs (including the cost of the education). Freedom from Hunger has also moved away from developing its own networks to deliver services toward integrating its service model directly into local institutional structures. This has proved to be even less costly and more successful and has allowed greater outreach and sustainability in less time.

Freedom from Hunger's microfinance strategy is built around the village banking methodology (see attachment 2) originally developed by FINCA in the early 1980s. It was further modified to strengthen the solidarity component among women and has performed extremely well in a variety of operating environments and institutional frameworks. The hub of this system is the Credit Association. This is a group of 30 to 35 women who have agreed to come together to borrow money, deposit savings and participate in the education program. This group is normally divided into five to six Solidarity Groups that can include five to seven women.

The Solidarity Group is designed to ensure strong cooperation among the women, ensure repayment of loans and spread the management burden for the Credit Association by devolving certain functions to the Solidarity Group. Women are not assigned to a Solidarity Group; they choose each other and form their own groups. Using this principle of self-selection ensures that the women are genuinely interested in working with each other, have a history of supporting each other and will work together in meeting their commitments.

The Credit Association functions like a small general assembly. There is a Management Committee that runs the meetings and maintains the accounting ledgers. It is elected by the members. There are also bylaws that govern the Credit Association. These are developed and voted on by the members. The Credit Association acts as a second social guarantee. If a Solidarity Group is unwilling or unable to repay a member's loan, the Credit Association will be responsible for meeting the obligation and dealing with the member or the group. Principal, interest and savings payments go from member to group and from group to Credit Association. Everyone is present during the weekly payment meetings of the Credit Association. It is during the weekly meetings that the opportunity to conduct education sessions occurs.

Loan sizes are set at very small amounts. They normally would range from \$50-\$300. The small size of the initial loan is designed to not overburden the management capacity of the borrower. It allows her to make some small initial investments with which she is familiar. There are no major capital purchases, no large inventories to manage, no new employees to train and no new technologies or methods to learn. The loan grows as the borrower is able to repay and save. This credit process builds the loan over time as a woman increases her investments in manageable increments and gains greater confidence.

Short lending cycles become critical to the success of the process. They are well suited to the nonformal income-generating activities of women (e.g., food processing, petty commerce, small-animal raising). The shorter the lending cycle, the less likely will be the risk of seeing the money invested in seasonal agricultural activities with weather-related risks. The diversification of the household risk among several activities creates an income-smoothing effect that enhances the overall food security of the household. The steady

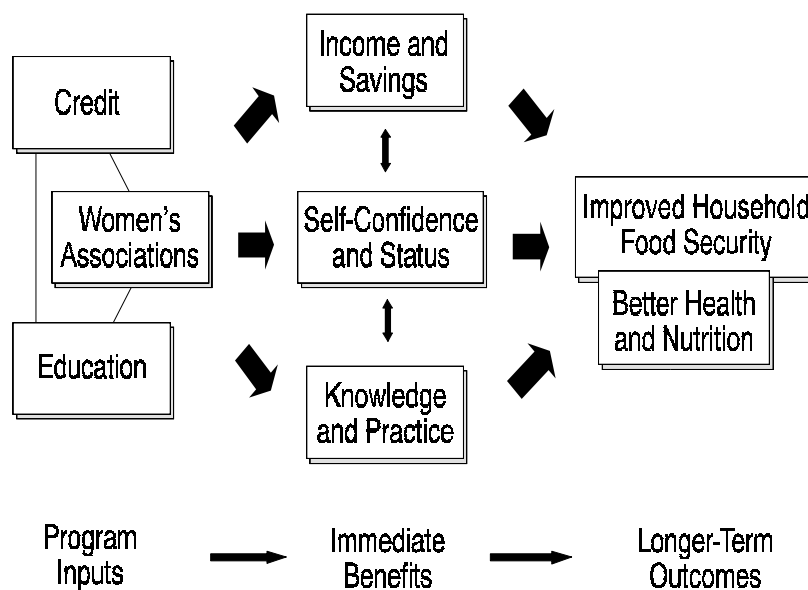
earnings these activities provide also facilitate the process of behavioral change being promoted through the education programs. It allows a woman to have a source of funds to purchase food and medicines and meet other basic needs to take better care of her child. Finally, with the short-term loan and short-term investments, the woman is in more immediate control of her assets and able to respond more quickly to the needs of her child. It provides her with a more flexible coping strategy.

In summary, *Credit with Education* is an integration of a village banking strategy to provide small-scale loans and education at weekly meetings to economically active poor women. The strategy is designed to promote improved maternal and child health practices while at the same time enhancing households' livelihood strategies. Participants form self-managed Credit Associations (village banks) and guarantee each other's individual loans. Members meet weekly to repay the principal and interest, deposit savings and learn about basic health and nutrition practices, family planning and small business management. The health education promotes ideal behaviors in the following areas: (1) diarrhea prevention and management, (2) breastfeeding, (3) infant and child feeding, (4) immunization, (5) family planning and (6) HIV/AIDS prevention and response. A high degree of loan recovery and the use of real interest rates and savings build a loan fund that can be recycled again and again. Interest and fee payments are used to pay administrative costs of program delivery.

Evaluation Methods and Results

Methods

Evaluation research was conducted with Lower Pra Rural Bank in Ghana (1993-1996) and in the Altiplano of Bolivia with CRECER (1994-1997). The primary study question was whether *Credit with Education*



improved the nutritional status of members' young children. The research also investigated impact on clients' economic capacity, their health/nutrition knowledge and practice and their empowerment under the assumption that positive change in each of these areas is a prerequisite for improved nutritional status of children. Baseline data was collected from mother/child pairs (Ghana, 370 pairs and Bolivia, 250 pairs) selected randomly from comprehensive lists prepared in each community of all the women having a one-year-old child. In the follow-up round, mother/child pairs (approximately 100 in Ghana and 85 in Bolivia) were sampled from each of three groups:

- Women who had participated in the *Credit with Education* program for at least one year.
- Women living in communities with the program but who had never joined.
- Women living in control communities (those randomly assigned to not receive the program during the three-year study).

Self-selection bias was minimized by randomly assigning study communities to either a program or control group and reclassifying baseline respondents in program communities on the basis of whether they ever joined the program when it was ultimately offered in their community. By comparing the measures of "future participants" (in the baseline, those who later joined the program) to 1996/7 actual participants, the difference between years can better be attributed to the impact of the program and not to inherent differences among respondent groups. Statistical significance was tested by comparing the difference in the various outcome measures between the years and whether there was a statistically significant interaction for year and participant status.

Results

Women's Economic Capacity

The majority of the 1997 participants reported their incomes had increased or increased greatly since joining the *Credit with Education* program. Participants most commonly attributed this improvement to the expansion of their income-generating activity, reduced input costs as a result of buying inputs in bulk or with cash, or the new activities or products made possible by access to credit and selling in new markets. But, perhaps even more than an income effect, clients' diversified loan-use strategies suggest the program allowed participants to augment households' assets, purchase foods in bulk and meet other basic needs. Participants also were significantly more likely to have their own personal savings than nonparticipants.

Women's Empowerment

Program participation had a positive and significant impact on whether women offered advice about good health/nutrition practices and good income-generating activities to others. These types of helping contacts and strengthened social networks can enable the program to have a positive community-wide impact beyond the direct participants alone.

Women's Health/Nutrition Knowledge and Practice

Relative to nonparticipants and/or controls, participants in the program reported positive changes in a variety of breastfeeding and feeding practices including: giving newborns colostrum, introducing

complementary foods closer to the ideal age of about 6 months and not using feeding bottles. In the area of diarrhea management, participants showed a positive difference in the promoted practice of giving more liquids to children suffering from diarrhea.

Child Nutrition

Ghana

The nutritional status (height-for-age and weight-for-age scores) of one-year-old children of participating mothers showed significant and positive differences from baseline measures as compared to one-year-olds living in control communities. The mean HAZ for one-year-olds dropped by 0.2 in control communities between the 1993 and 1996 periods. When controlling for children's age and maternal height, there was a significant interaction between year and participant status when comparing participants and controls. The same significant and positive interaction effect was found when conducting similar analysis on the one-year-olds' mean weight-for-age z-scores. This indicates that for the two time periods, *Credit with Education* had a positive and significant impact on the nutritional status of participants' one-year-old children.

Bolivia

The nutritional status of participants' one-year-old children—as measured by mean height-for-age, weight-for-age and weight-for-height z-scores—did not show a positive difference relative to the children of nonparticipants and controls. Over the study period, the pattern seen in the nutritional status of participants' children was similar to the one seen for children in control communities; it remained relatively constant or was even lower in the follow-up period. However, further analysis of the participant sample showed some difference by the quality of education received. Although the sample sizes are small, children of clients who received the relatively “worst” education services had poorer nutritional status in the follow-up period. Between the baseline and follow-up periods there was a significant and positive relationship in the quality of education received and its impact on children's mean weight-for-age z-scores and the prevalence of moderate to severe malnutrition when controlling for a variety of child, household, community and provincial variables.

Evaluation Conclusion

The impact evaluation research provides evidence that credit and education services, when provided together to groups of women, can alleviate poverty, improve health/nutrition knowledge and practice, and empower women. Positive impact on the nutritional status of clients' young children was not evident in Bolivia, except when deeper analysis of the client group alone revealed that children's weight-for-age was positively associated with the quality of the education services provided. This finding supports one of the central assumptions underlying the design of the *Credit with Education* strategy—that without important improvements in caregiver practices, income increases and even empowerment are unlikely to bring about marked improvement in children's nutritional status. This finding also highlights the importance of program management attention to the quality of the nonformal education services. The combination of positive impact and financial sustainability makes *Credit with Education* a strategy with exciting potential for widespread and sustainable impact on households' economic capacity, on women's empowerment and

ultimately on household food, nutrition security and child survival.

Lessons Learned and Response – Field Staff-Centered Management

Many programs have developed adequate systems of supervision. But more may be needed to ensure that field staff are willing and able to achieve the impact objectives of the program. Program managers need guidance for recruiting, training and supervising field supervisors to do good supervision that steers field agent performance toward program objectives. What is needed is management philosophy and systematic practice that is centered on field staff.

The Case for Field Staff-Centered Management

A good program is characterized by service orientation to its clients. This is achieved by having the right service package (*Credit with Education* or something similar) and the right policies for program management for achieving the following:

- **client satisfaction** (if they're not satisfied, they won't stay with the program and they'll share their dissatisfaction with others who might have joined later)
- **social benefits** (without achieving social benefits, net of costs, how can investment in program start-ups and expansion be justified to donors or investors?)
- **sustainable institution building** (to generate a revenue stream that allows the program to keep on serving its clients and adding new ones)

Field staff are the primary means to these ends. They deliver the service package that satisfies the clients and produces benefits for the clients and their families. Field staff are the sales force, the revenue generators, the program's interface with the clients. To the clients, the field agents are the program. The program's success depends on the success of its field staff. Therefore, **the philosophy and practice of management should be "field staff-centered."**

What Field Staff Need

Field staff-centered management has only two major components: signaling and support. Through recruitment, training and supervision (and incentives) there should be **clear and consistent signals** from supervisors to field staff about what good field staff are expected to do and how valuable they are to the program when they do it well. Also, the management and administrative functions of the program should be structured to enable the supervisor to provide the field staff with **adequate and timely support** to do their jobs well. This is both what field staff need and what they want.

Most programs probably do better at support than signaling. Support activities are more obviously indispensable and more familiar to us all in our daily lives. When program management provides good support to field staff, such support itself is an excellent signal to field staff that their work is critically necessary for achieving program objectives. In fact, **support can be considered one of five activities that send signals to steer field agent performance toward program objectives: recruitment,**

training, supervision, incentives and support. This perspective allows us to focus on **signaling** as the key ingredient in field staff-centered management.

Managers of field staff-centered supervision and incentives systems need information about field staff performance and how this performance relates to achievement of the program's objectives. There is a critical need for a manageable system for supervisors to collect the right information at the right time and to analyze and return this digested information to field agents. Much innovative work is needed to fill the need. This collection and feedback of performance information to field staff should become a routine part of the art of ongoing supervision, not a separate system of "monitoring and evaluation." To make a clear distinction, the new term "progress tracking" will be used to label this approach.

Progress Tracking

"Progress" means movement toward something; the journey is important, but mainly because it moves us closer to a chosen, desirable destination. "Tracking" means either the seeking and following of signs, as in a hunter tracking an animal, or staying on a previously laid out track or path; both meanings are appropriate for our purposes.

A map is a good metaphor for understanding the conceptual framework for progress tracking. For the map to be useful for our journey, we have to know our destination and locate it on the map—for progress tracking, call this destination the desired "ultimate impact" of our program. And we have to know where we are now on the map—our starting point or baseline. And we have to find a route of travel on the map in relation to the difficult terrain between our current location and our destination—call this route our "hypothesis" that our program will convert specified inputs into outputs that lead to intermediate effects that will in turn lead to the ultimate impact(s) we seek. And from the map, we have to identify landmarks along our route of travel that, when found on our journey, will reassure us that we are on the right track—call these our "indicators" of progress toward the ultimate impact(s).

The map is a hypothesis for action, showing us a chain of cause and effect leading from our actions to the ultimate impacts we seek. This diagram (see attachment 3) serves as the conceptual framework for Freedom from Hunger's carefully controlled, longitudinal impact research studies in Bolivia and Ghana and later in other countries. The accumulating evidence supports the validity of the *Credit with Education* hypothesis: integrated village banking and non-formal nutrition education can generate profitable economic activity, savings and empowerment for very poor women, as well as increase their health and nutrition knowledge and improve their childcare practices, leading to improvements in household food security and better nutritional status of young children.

Freedom from Hunger believes this constitutes sufficient evidence to justify substantial investment in *Credit with Education*—that the map is sufficiently accurate to provide reassurance to both donors and program managers that their efforts will be rewarded by the intended impacts if the program can stay on the recommended route of implementation.

Progress tracking is not about proving the accuracy of the map. It is about using the map regularly to check position and progress toward intended impacts, the destination that is promised by the map to be at the end of the recommended route of implementation. But the mapmakers (the researchers) must show more detailed information about landmarks of progress that program managers can find along the route.

Evidence from scientific impact studies must be transformed or translated into indicators of progress toward the ultimate impacts. Researchers need to identify the impact variables in their scientific studies that were most affected by program participation and that seem relatively easy to measure. These can become landmarks, or indicators of progress, on the map.

Even with a good map, we would have two more steps to take to create a progress-tracking system.

First, we need to create an indicator-measuring-and-reporting system which can be managed by program staff and regularly and meaningfully inform program-steering decisions. The system must be cost-effective in producing information that is credible and useful. **Second**, we need to embed this system in the routine of effective supervision.

The motto of progress tracking might be, **“Look for changes in the right direction and reward them.”** A corollary motto is, “If you want it to happen, measure it and report the results to the people who can make it happen.” Conversely, program experience shows that if you don’t measure and report it (whatever “it” is), you won’t think about it, and if you don’t think about it, it won’t happen. The key to putting this simple wisdom into practice is deciding **what** to measure and report

Option 4: Multisectoral Approach to Child Health and Development

- Directly address education, income generation and capacity-building of local service delivery organization to promote adoption of key practices.

Cross-Cutting Strategy

- Form partnerships to increase scale of intervention and effectiveness.
- Sustain community-based practitioners.

¹ Social Enterprises are social service institutions that incorporate business strategies and management practices common to commercial enterprises. The purpose is to enhance social impacts through more demand-driven, professionally managed services while creating an opportunity to recover a greater share of costs through client-generated fees and revenues.

The Indian Experience in Developing a Training Package for Capacity Building of Basic Health Workers in Integrated Management of Childhood Illness

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Introduction

In India 4 million children die each year mostly due to five common killer diseases. 30 % of population in India live in abject poverty with a income of less than \$1 per day. This compromised household livelihood security brings in a attitude of servitude, where every day is a struggle to survive. The worst impact of this is on the most vulnerable group i.e., women & children. India has developed the biggest rural health care delivery system in the world They have 131,369 rural primary health care center with facilities for provision of preventive /promotive and basic curative care . Qualified health care professionals man these posts . The quality of services available in these rural health center is variable , similarly more often than not the Auxillary Nurse Midwife posted in these rural health centers stay in nearby town affecting the accessibility and availability of these services.

In contrast another government sponsored program “Integrated Child development Scheme” provides a comprehensive package of services by using a community volunteer Anganwadi Worker “AWW “ who is a local resident . The AWW is not a trained health worker but is accessible to the community for 24 hours /7days a week . It is there fore most logical to to built the capacities of these AWW for dealing with home management of these killer diseases & to train ANM to provide quality supervision for them.

Description of Program

Training Package for the Basic Health Worker: A large number of sick children are brought to the AWWs who often are the first contact for the sick child in the community and provide home care services . Although the AWWs provide a great deal of services, they have low literacy levels and limited clinical training . She only receives some basic health and nutrition training during her pre service and refresher trainings. ANM on the other hand is a trained health professional but her supervision & training skills are limited . Therefore both of them need empowerment through appropriate training to enable them to deal with common childhood problems at the village level. A package was developed, accordingly, keeping in focus the existing enviroment in Indian context.

CARE India in joint collaboration with WHO/ SEARO, National Institute of Public Cooperation and Child Development (NIPCCD), National Institute of Health and Family Welfare (NIHFW) and Society for

Woman and Child Health (SWACH) worked in partnership to adapt, develop and field test a training package and training course for BHWs and their trainers. The BHW course was developed as a 5 days capsule with hands on practice at community and hospital settings which is fully compatible with the 11-days IMCI training package for first level facility.

Steps of development of the IMCI training package for India

- Facilitating Interagency for collaboration & Prioritization of interventions
- Adaptation of the curriculum to Indian context
- Development Pre-testing and translation of training package
- Training of trainers for master trainers
- Field-testing with BHWs in six states and sharing experiences at the national level
- International advocacy and marketing

The training kit consisted of, Learners guide, and trainers guide, colored clinical photograph booklet. Video illustrating key signs with exercises for practice, job aids in form of laminated card, monitoring tools, mothers cards, & supervisory tools. A total 7 field workshops were held in which 184 participants were trained using 47 facilitators. (4:1). The training experience was very cost effective. Similarly the community level practical provided a opportunity to the BHW to work in settings similar to their work experience.

Lessons Learned

- Focus equally on technical component and communication skills
- Use interactive training methods
- Offer hands on clinical experience
- Use community as a setting for training
- Creating training aids for semi-literate BHWs
- Establish training ability of BHW supervisors

Discussion

The training for basic health worker can only be useful if there is concomitant implementation of IMCI at the facility level. This training created lot of interest but failed in producing lasting impact since IMCI was not implemented at facility level and availability of health supplies were not adequate. The incorporation of the BHW package into the regular government Reproductive Child Health Program can provide the BHW with a comprehensive tool to make a positive difference in the most vulnerable section of the community, the mother and the child. Its incorporation needs to be done at all level i.e., facility as well as community & family level needs to be done simultaneously. Replicating the effort nationally and internationally to see effectiveness of package in different contexts. There is a need for further adaptation of the package for an illiterate worker would widen the reach of the skills and therefore the access of the community to promotive, preventive and curative services.

Community Initiative in Management of Childhood Illnesses: Partnering with Communities for IMCI Case Management

VINCENT ORIMBA

CARE INTERNATIONAL/KENYA

(see page A-91 for definition of acronyms used in this article)

Overview of the Project

Community Initiatives for Child Survival in Siaya (CICSS) Project officially commenced as a four-year project on 29th September 1995 and is currently on its second phase, which started in October 1st 1999 to September 29th 2003. The CICSS II project is intended to build upon the foundations of the impressive results realized by CICSS I between 1995 and 1999. Its goal is to improve health status in the divisions by reducing the mortality and morbidity of children under the age of five. The project also aims at improvement of the health status of women of reproductive age and to increase the capacity of community committees, the Ministry of Health and other local institutions.

CICSS adapted the WHO/UNICEF Integrated Management of Childhood Illnesses (IMCI) algorithms for community use in conjunction with the Bamako Initiative approaches for establishing community pharmacies. To this end, the project has developed training material employing IMCI guidelines for cough or difficult breathing, fever and diarrhoea, counseling mothers on home care, when to return to the CHW and for appropriate referral.

The project focuses on the management of the commonest causes of childhood morbidity and mortality with the main areas of concern being the management and prevention of malaria, pneumonia, diarrhoeal diseases, while promoting immunization, family planning and HIV and AIDS control activities. The project has integrated vitamin A activities into its implementation strategy where vitamin A capsules are dispensed as part of case management and the compensation of vitamin A rich foods are promoted within the community.

In this context improved home care and easy availability and accessibility to the basic health care services through trained CHW has resulted in significant (49%) reduction in the CMR. The Project area is located in an area where Infant Mortality Rates (IMR) and Under Five Mortality, with an annual (U5MR) of nearly double the national average at 102 and 210 per 1000 live births (74/1000 and 112/1000 respectively). Factors responsible for this poor rate of infant and child survival include poverty; inadequate knowledge; inadequate hygiene and sanitation; protection and treatment against common transmissible diseases such as malaria, ARI, diarrhoeal diseases, and measles; and HIV/AIDS, including transmission of

HIV from mother to child. Moreover, poor road infrastructure and sparsely located health facilities place the majority of the local people within a 3 – 15 km walk for accessing the facilities. The project intervention targets 40 communities in 3 divisions within the district. The estimated population is approximately 193000 rural residents with a potential beneficiary number of 41000 women of 15-49 years and 36000 children aged below five years.

In-Depth Description of HH/C IMCI Implementation and Crosscutting Activity

Project Design – CICCIS I

This project was implemented by community based voluntary health workers called community health workers about five hundred were trained over the life of the project. The first two year target trained about 368 operational CHWs. These CHWs were recruited after initial social mobilization following established selection criteria. Area CHWs was determined using existing clan boundaries in each administrative unit (sub-location). A second group of CHWs was trained during the last phase of CICCIS one project. The CHWs were proposed, nominated and confirmed in a special public meetings convened by local administrator (Assistant Chief) and included local Ministry of Health field staff responsible for the area. After the group was established, it formed the Management Committee to be supervised by the Village Health Committee, a similarly constituted group of elders, both men and women representing interest of various clans and special religious sect identified in the baseline survey.

The Bamako initiative pharmacy model developed by UNICEF provided essential drugs and impregnated mosquito nets. This provided ease of access. The revolving drug fund generated from the sales of initial supplies enabled the circle to become self sustaining. The health education component used women groups as entry points. The cost sharing involved did not exclude the poorest of the eligible family. The overall watchdog, the VHC is comprised of the elders from all the villages who identify those who cannot afford the payments. The village health committee determines policy on payment schedules and when to waive percentage costs. Each CHW is responsible of looking after 10 to 20 homesteads. This includes 50 to 30 eligible children from the CHWs home village. The CHWs record information on the local “Chalk and Board database” which is a community level record of all major events in the community related to health.

Project Design CICCIS II

The overall program design is based on the realization that sustained health benefits at the community level requires co-ordination among stake holders at all levels, including the community, sub-location authorities, DHMT, local NGOs, other institutions and collaborating partners.

All proposed activities lead to the achievement of specific health outcomes/objectives and can be grouped by disease such as malaria, ARI and CDD. Activities will be clustered to show their contribution to capacity building objectives at different levels of intervention.

Project interventions

- i). Acute lower respiratory tract infections (ALRI):* The goal – to increase the proportion of children with pneumonia who receive appropriate timely treatment according to the Integrated Management of Childhood Illnesses, and to promote health seeking behavior by the child care takers on recognition of signs of pneumonia.
- ii) Malaria Control:* To increase the proportion of children with clinical malaria who are appropriately treated, and the proportion of children less than 5 years and mothers who sleep under insecticide treated mosquito bed nets. The goal for the children already with malaria is the increase in the proportion of those receiving treatment within 24hrs. of onset of illness.
- iii) Proportion of increased Immunization coverage:* Increase from 45.7% to 70% the proportion of children 12 to 23 months that get measles vaccine.
- iv) Improved Management and Prevention of Diarrhoea and Dehydration:* Increase the proportion of children with diarrhoea who are managed on Oral Rehydration Therapy including home based fluid, and to increase the proportion of infants less than 2 months exclusively breast fed.
- v). Maternal Health Care and Family Planning:* Increase from 1% to 40% the proportion of expectant women who currently take sulfadoxine – pyrimethamine as malaria prophylactics in the second and third trimester, and from 80% to 90% who receive one or more doses of tetanus toxoid. The other goal is to increase from 14% to 30% the proportion of women 15 to 49 years who use modern methods of contraception.
- vi) Sexually Transmitted Infections (STIs) and HIV/AIDS:* Monitor the condoms distributed per population 15 to 49 years in the previous 12 months, and reduce the proportion of the people in the same age group reporting having had sex with non regular partners.

The project has used the following major strategic directions

- i) Improved capacity:* of the local community to address health issues through increased Information, Education and Communication (IEC) and health education conducted by trained nominated personnel called Community Health Workers (CHWs).
- ii). Increasing access:* to drugs and health care for the management of common ailments by initiation of community based pharmacies (Bamako Initiative – BI-Pharmacies), through which drugs for treatment of pneumonia, malaria and other endemic ailments are made available to the community. The proceeds from sales of these drugs, and mosquito bed nets, are available for re-stocking (as a revolving fund) of the pharmacies and to finance other community based curative, promotive and preventive health projects. The trained and certified CHWs stock the drugs in kits they keep at their homes in the villages thereby further increasing access to drugs and skilled care.

- iii). Increased use of health data*, generated from the community by the CHWs, at the community is captured on the chalkboard, analyzed by the community, and used for decision making at that level.
- iv). Increased collaboration and networking* with the District Medical Officer of Health (DMOH) and his staff and other agencies participating in health in the project area. Collaboration occurs in the area of training of project participants, supervision, and project monitoring.

ACHIEVEMENTS

- i). Mobilization:* 23 out of the 40 communities, have been identified for initial project implementation. The criteria used included distance from the nearest health facility, absence of any community based health activity in that community, and difficulty to reach, i.e. inaccessibility. These 23 communities have been fully mobilized, and 276 VHCs, and 406 CHWs appointed, trained on the concepts of PHC/CBHC. As a result of the mid term evaluation in October 1997, 2 other communities are being mobilized for project implementation for this first phase and the other 15 sub-location are earmarked for project implementation during the second phase of the CICC project in 1999-2003
- ii). Training and skills development*
 - Staff:** The staff were trained on Standard Case Management (SCM) of childhood illnesses – Acute Respiratory Tract Infections (ARI), Control of Diarrhoea Diseases (CDD), and Malaria, by the Ministry of Health. As a result of the SCM it was possible for the senior project team to adapt the training materials for the WHO Integrated Management of Childhood Illnesses (IMCI) used for training both the extension workers and the CHWs. The adapted format is now known as case management of childhood illnesses (CMCI). All staff have been trained on VITACIP activities which have been integrated into CICC activities.
 - Community:** All the 406 CHWs from the 23 communities were fully trained on clinical management of childhood illnesses, and have started implementing curative and preventive health services to the communities they represent. Currently, 313 are active in the communities and efforts have been made to replace the dropped out CHWs from the communities. All the VHCs and CHWs of the 23 communities fully trained on project and financial management. 313 CHWs have been trained on Vitamin A and 296 are currently dispensing vitamin A capsules as part of case management.
- iii). Household survey:* The CHWs and the VHCs participated in the community based demographic survey in 1997 in order to learn the communities and to develop data upon which their projected planning and activities are to be based. The result is the CHWs now know their areas in terms of population and the other resources available. The result of this survey are updated periodically by the CHWs.

iv). Procurement and Supplies of the communities: CHWs drug kits were formulated with consultations and concurrence with the District Medical Officer of Health, and have been purchased for all the 397 CHWs that are active. 500 Mosquito bed nets have been purchased for use in each of the 23 communities. Plans are under-way to establish a system for the procurement of these items independent of the CARE's system for further sustainability.

By December 1999, all 23 communities had made independent orders through CARE for the replacement of essential drugs that have been cleared in their communities.

v). Service Provision: Community based management of common childhood illnesses pneumonia, malaria, diarrhoea, and others like worms have been launched and are on going in the 23 communities of these two divisions. Home visits and health education sessions by CHWs at meetings and barazas has brought health care to doorsteps of the village members.

Cross Cutting Activities

Sustainability

The major challenge facing the CICSS II project is to identify and promote/support community mechanisms capable of sustaining the significant impact on child mortality in the project area that has been realized under CICSS I. to this end then, the project defines sustainability in the context of CICSS II.

The ability of local structures and institutions (household, community and MOH) to promote, manage, support and maintain personal behaviors, the delivery of services and collective actions capable of sustaining improvements in health and reductions in child mortality in the absence of external assistance.

As such, sustainability is clearly a complex issue, which requires careful attention over the life of the project. The CICSS II project sustainability strategy recognizes several different "types" of sustainability, which must necessarily be addressed if the overall goal/definition is to be achieved. These are:

- a. Financial:* Financial sustainability refers to the ability of community structures and local institutions to continue to provide the inputs necessary (not exclusively financial, but material as well) to promote, manage and maintain the key behaviors, services and collective actions necessary to sustain project effects and impact.
- b. Organizational/Institutional:* Organizational/institutional sustainability address the ability of communities, groups and institutions to continue to support, manage and sustain the key behaviors, services and collective actions necessary to sustain project effects and impact.
- c. Human:* Human sustainability refers to the ability of community and other local human resources to continue to promote, manage and maintain the key actions and interventions necessary to sustain project effects and impact.

- d. **Material/Technological:*** Material/technological sustainability refers to the availability and continued functionality of the materials and technologies necessary to maintain the key actions and interventions necessary to sustain project effects and impacts.
- e. **Social:*** Social sustainability refers to the sustained demand by local beneficiaries, consumers and participants for the key behaviors, services and collective actions necessary to sustain project effects and impacts.
- f. **Political/Policy:*** Political/Policy Sustainability refers the continued support of political and policy institutions for the key behaviors, services and collective actions necessary to sustain project effects and impacts.

The overall sustainability goal for the CICSS II project is to create an environment capable of sustaining the project's impact (reduction of infant and child mortality). In order to do that however, it appears that several of the (currently) provided project inputs may also need to be sustained.

Based upon the CICSS I experience, the project has identified a number of threats to the sustainability of both impact and the inputs required sustaining it.

Several strategies will be employed by the project to address these threats and to build towards all types of sustainability. They include:

- 1. Cost Recovery:** The project will increase the availability of key essential drugs and materials (principally bednet, re-treatment chemicals, condoms) in support of the application of the CICSS I developed CMCI approach and its treatment algorithms. The project will do so in a way, which addresses the question of the financial sustainability of efforts to increase drug availability. All of these drugs and supplies (except condoms, which are received and distributed free,) are sold by the sub-location-based pharmacies to CHWs on a cash and carry basis in order to recover their costs and therefore insure their availability. CHWs in turn sell the drugs and supplies to patients or their caretakers as indicated by the CMCI treatment algorithms.

The project has already equipped CHWs in 25 sub-locations with an initial kit of drugs for sale to patients. It has also established 25 BI pharmacies in those same locations to serve as re-supply points for the local CHWs. All continue to function although there have been reported difficulties with patients who are unable to pay for drugs received (creating a deficit for the CHW's revolving fund) and CHWs who have "borrowed" from their revolving drug fund. Both situations endanger the sustainability of the funds and therefore drug supply in those communities. The project will address this issue with continued training and supervision of CHWs. It will also encourage and support communities to come up with solutions to this problem such as: creation of loan funds to support the treatment of indigent patients, loan fund for CHWs so that they may insure the viability of their drug fund, other financial incentives for CHWs to eliminate the need for them to "borrow" from their drug fund and the possibility of supporting other income generating activities for CHWs so that they will not need to "borrow".

2. **Capacity Building:** This strategy will be employed aggressively by the project in order to address issues related to human sustainability. Capacity building will be used to insure those local and community individuals, structures and institutions have the capabilities and skills needed to carry on with project activities and therefore sustain project impact. The capacity building activities planned for the project is described in detail below (see Section 1: I Training). Capacity building activities are planned for all levels of project intervention (household, community/village, sub-location, and district).
3. **Cost and Responsibility Assumption:** There are a number of costs associated with the project, which cannot be, recovered through traditional user fee or other cost recovery mechanisms. These include supervision costs, training costs and the costs of other supplies associated with the operations of the CHWs and SHCs (the patient's registers, accounting forms and books, etc.). Attempting to include these costs in the cost of drugs sold would result in prices which would be unaffordable to many in the project area communities and have a potentially damaging effect on utilization and project impact as a result. There are indications already that the low prices charged for drugs by the CHWs are still too expensive for some. This results in either un-served patients or debts, which are difficult to recover or clear. This situation, of course, poses a significant danger to the revolving funds viability in the long run. Increasing prices to recover a greater percentage of all project costs appears therefore to be undesirable and unfeasible.

The project must therefore find partners who will progressively assume these costs if activities are to be sustained beyond the termination of CICSS II funding in 2003. The creation of the joint CICSS/MOH Task Force at the district level in Siaya has created a forum and opportunity to explore the MOH's potential to commit to assuming these costs of the project. The project will continue to use this task Force as an opportunity to continue to urge the MOH to progressively commit resources to activities in support of CICSS II goals and objectives.

The MOH is not the only partner, which may be expected to assume costs as part of a CICSS II sustainability strategy. The project will encourage communities through the SHCs to assume costs associated with training, supervision and operation of their CHWs. This may take the form of providing lunch (or an allowance) for CHWs while they undergo refresher training for example. SHCs will be encouraged to generate resources locally (and possibly create a fund) that they will manage and use to progressively assume reasonable (and difficult to recover through drug or user fee mechanisms) recurrent costs of supporting the work of their CHWs and the operation of BI pharmacies. Many communities currently rent space for their pharmacy. This is an important and encouraging example of their ability to commit to the assumption of specific recurrent costs. These examples will be expanded upon and shared. Many of these same communities are currently looking for ways to generate the funds in order to build their own pharmacy building in order to eliminate this cost in the future.

The assumption of the cost of sustained support and supervision alone are not sufficient to guarantee the sustained impact of the community based structures and behaviors, which have been promoted by the project.

4. **Efficiency:** In order to improve its chances of financial sustainability (to be achieved primarily through cost recovery and/or cost assumption) the project must also insure that it has defined the least expensive set of inputs required to sustain the desired impact. The project must find the most cost-effective ways to deliver and support the important services delivered by CHWs. The project will use an operations research approach to reducing cost of support while sustaining impact.
5. **Community Mobilization:** Sustainable demands for project interventions will be created through a strategy of aggressive community mobilization. The CICSS I project have done an impressive job of mobilizing communities in the 25 sub-locations that it has worked to date. Community's leaders are supportive and appreciative of the project and beginning to look for ways to locally solve problems identified. The project will continue to build and support this capacity as a means of insuring the social sustainability of the project interventions and therefore their impact.
6. **Training of CHWS:** One of the major capacities building components in CICSS project is training. For the last few years the project has put various systems in place, which has made it possible to achieve some reduction in child mortality rate 7% to 49% of children 0-5 years. The project has built the capacity of service delivery providers to deliver quality health in the project areas. Based on these results (KPC final) the project has to address the identified gaps in capacity building in order to achieve more successes in phase II of the project implementation.

Training will be aimed at sealing gaps identified in CICSS I and laying ground for CICSS II through development of skills and knowledge of CARE, MOH and community for sustainability of the program. The training will be in 3 categories depending on the type of knowledge and skills to be imparted.

They are:

- I. Initial training** which will be the training given to staff covering PHC/CBHC concepts and relevant child survival intervention and reproductive health issues
- II. Refresher training** which will bridge the gaps, which have been identified during implementation by staff and community health workers and Village Health Committee.
- III. On job training (continuous support)** which will be the continuous support to the staff and community to sustain the benefits and will be carried out through home visits, clinical assessments, updates on new developments, meetings and exchange visits.

The training pattern in CICSS II will be fully community based and cost-sharing mechanism will be worked out between CARE, the MOH and the community. This will be through dialogue on issues of cost, risk and responsibility sharing during training for promoting sustainable activities. They will also jointly make decisions on the identification of MOH participating staff, community TOTs whose capacity will be built to take care of community training needs and supervision accordingly.

7. **Supervision:** CICSS I laid the ground for supervision and monitoring which was mostly carried out by CARE. CICSS II will emphasize on establishing strong linkages with the MOH, community and other agencies that are operating in the area to provide a sustainable support-a-vision mechanism to VHCs, CHWs and existing CBDs. The next phase of the project will rely more on the MOH staff at the health facilities, (ECN's and PHT's) to play a more active role in the supervision of CHWs and SHC activities. An agreement between the MOH and CARE will be drawn up where the supervisory structure will be outlined.

Since 1997, 350 CHWs have undertaken a 15-day training course in case management and are providing services in the community. To update their skills, regular continuous assessment sessions are conducted in the health facility supervised by the CARE extension workers and health facility staff. Every two years, in conjunction with the Centers for Disease Control and Prevention in Atlanta, a sample of 120 CHW have been assessed for their clinical proficiency. The findings obtained have been used to develop refresher-training curricula.

Community health workers are managed and supervised by 23 village health committees, one in each sublocation containing almost 200 members. Twenty-three community pharmacies have been established which have provided affordable access to drugs and nets to the communities. Through a revolving fund, replenishment of the drugs in each pharmacy has occurred through an established independent mechanism.

The first phase of the project underwent a final evaluation last June 1999, which showed positive results. Delivery of care in the community by the CHWs has resulted in more rapid seeking behavior, lower cost to families and improved outcomes, with the greatest benefit being in the management of malaria. The quality of care provided in the community is also high with a lot of community support of for the services of the CHWs. A community led immunization strategy has led to improved immunization rates in the project area, when the rates are declining countrywide. To date, approximately 25,000 cases have been assessed by CHWs in the community.

In the next three years, the project will focus on strengthening the capacity of community committees and the local ministry of health and other local institutions to sustain the activities established during the first phase of the project.

Add on Projects

Due to the high interest and potential for success that the project has generated worldwide, other projects have been integrated into the CICCIS project taking advantage of the existing infrastructure to create a higher project impact.

- a) ***Vitamin A Community Initiatives Project (VITACIP)***: The project seeks to address the problem of vitamin A deficiency, which is quite prevalent in the province. This is through increasing the community access to the utilization of vitamin A supplements and food sources of vitamin A. The project ended in December 1999 after a food frequency survey was conducted by the project.
- b) ***CARE/CDC Health Initiative (CCHI)***: This is a collaboration between CARE and CDC whose goal is to strengthen supervision, training, the targeting of interventions, and monitoring in the CICCIS project and evaluation of project impact. This is by taking advantage of CARE's extensive experience in developing the capacity of communities with CDC's skills in epidemiology, particularly as applied to monitoring, evaluation and operational research.
- c) ***MEDTRONICS FOUNDATION***: The organization has an interest in improving the health of disadvantaged women and children. Their funding has been used to develop a project ICE strategy and material production.

Lessons Learnt

- a) Due to the complexity in implementing the project activities in the 23 sub-locations, the project would hold off expanding to the other 17 sub-locations in the rest of the project life. Plans should then be made to develop a follow on project to go into these other areas. The project team then decided to expand to 2 other sub-locations, which would serve as model communities to apply the lessons learnt so far.
- b) Due to the complexity in implementing the first four interventions, i.e. pneumonia, malaria and diarrhoea control and promotion of immunization, the project was unable to go into HIV/AIDS prevention and family planning fully in the 23 sub-locations. Instead, it would pilot these interventions in five sub-locations only in this current phase of the project.
- c) Knowledge of care seeking and disease prevention messages are substantially higher in the project area than in adjacent non project area, but mothers do not always recall care seeking messages delivered by CHWs on signs of significant illnesses. Also found were major gaps related to counseling on care to be given at the home, and hence there was need to review the key messages on home care. The MTE team recommended that the project develops messages and materials to teach signs for care seeking and health maintenance and for this reason, JHU has been consulted to help improve the project IEC strategy. The consultancy commenced in June and is to be complete by the end of the year.

Best Practices

- Programmed Clinical Assessment for CHWs
- Structured mobilization process targeting the weak areas
- Mortality review of activities with communities
- Staff monthly meetings for reviewing progress
- Development of standardized IMCI training materials
- Capacity building of staff to enable to transfer the skills to CHWs
- Developed M&E system in place
- Successful studies that help in improving quality programming

Challenges

- Retention of volunteers to continue with the provision of health care
- Capacity of the VHCs to use information for decision making
- Slow pace of which community owns-up project activities
- Integrated of herbalists/traditional medicine men into the IMCE protocols for CHW

Acronyms Used in the Above Paper

AIDS	Acquired Immunodeficiency Syndrome
BI	Bamako Initiative Pharmacy
CBA	Community Based Advisor
CBD	Community Based Distributors of Contraceptives
CCHI	CARE/CDC Health Initiative
CDC	Center for Disease Control and Prevention
CHW	Community Health Worker
CICSS	Community Initiative for Child Survival Siaya
CMCI	Case Management of Childhood Illnesses
DHMT	District Health Management Team
DMOH	District Medical Officer of Health
FHC	Field Health Coordinator
FY	Fiscal Year
HIS	Health Information System
HIV	Human Deficiency Virus
IGA	Income Generating Activity
M&E	Monitoring and Evaluation
MOU	Memorandum of Understanding
VAC	Vitamin A Capsule
SHC	Sub-location health committee
ECN	Enrolled Community Nurse
PHT	Public Health Technician
KPC	Knowledge and Practice Coverage
IEC	Information Education and Communication
SCM	Standard Case Management

Partnering With Traditional Healers and Drug Sellers in Uganda

Jolene Mullins, Uganda Project Director
Minnesota International Health Volunteers

Overview of Project/Activities

Introduction

Minnesota International Health Volunteers (MIHV) has carried out USAID-funded child survival activities in Uganda since 1992. The first child survival project (1992-96) focused on perinatal and maternal health, partner capacity building, and training of community volunteers and peer educators in malaria control, control of diarrheal disease, and optimal breastfeeding and weaning practices. MIHV provided clinic staff with technical updates but achieved its greatest impact by working with traditional birth attendants (TBAs). MIHV learned that in remote and highly rural areas where clinics are difficult to access, the involvement of highly respected community-level practitioners is essential, not just to provide life-saving services, but also to give credibility to project interventions and to mobilize communities to improve health. If TBAs encourage caretakers to immunize their children, they are more likely to comply; similar pronouncements by politicians or health care providers may be regarded with suspicion. Given this experience, MIHV decided to expand its work with community providers (1) to focus on prevention and treatment of childhood malaria and diarrheal disease and (2) to include additional cadres.

Since 1997, MIHV has used private funds (primarily from the Conservation, Food, and Health Foundation), to train TBAs, traditional healers (THs), and drug vendors (DVs) to (1) recognize symptoms of major childhood illnesses, (2) provide improved services to ill children, (3) refer seriously ill children, and (4) mobilize communities to protect and improve child health. Through these activities, community providers, working in cooperation with the District Health Team (DHT) and clinic staff, have extended the reach of public sector health services and significantly improved caretaker knowledge and clinic usage.

The Project Area

Ssembabule District is located in southwestern Uganda approximately 200 km from the capital city, Kampala. The district is comprised of two counties, six subcounties, and approximately 270 villages. Covering a geographic area of 2500 sq. km, Ssembabule is home to a population of 180,000, including approximately 33,000 children under the age of five and 31,000 women of reproductive age. The district is extremely rural and has very limited infrastructure: there are no paved roads, no access to electricity or modern communication, and no central water and sewage system. The population's major source of income is agriculture and animal husbandry. The district experiences severe water shortages; crop failure and migration in search of water for livestock are not unusual.

The infant mortality rate in the area was estimated by the Ministry of Health to be 107 per 1,000 live births; mortality among children under the age of five was estimated to be 178 per 1,000 live births. Maternal mortality in the area was estimated at between 504-610 per 100,000. Leading causes of child mortality

include malaria, acute respiratory infection, and diarrhea. MIHV's baseline KPC (1996) noted that 39% of mothers reported a diarrhea episode in their under-five during the past two weeks; of these, only 29% had been given ORS, while 61% had been given an antibiotic and/or antidiarrheal. According to 1993 district data, between 14% and 57% of under-five children were clinically diagnosed with malaria each month. Mothers interviewed as part of MIHV's baseline KPC identified malaria as the most serious health problem facing both children and women. According to this baseline KPC, virtually all children with presumed malaria (18/19) received some care, half from a drug shop and half from a clinic or private doctor. The MOH reports that nationally chronic malnutrition affects 45% of under-five children.

When MIHV began implementing its CS project in Ssembabule in 1992, there was no tertiary care in the project area. Ssembabule had seven static clinic sites, including one health center in Ssembabule town. The health center was responsible for referral of serious cases from surrounding villages and for providing minimal emergency services. The health center had no physician and, for the first four years of the project, no medical assistant. Referral for obstetric and medical emergencies was made to the nearest hospital, approximately 50 km. away.

In 1998, Ssembabule was one of six Ugandan districts to be granted autonomy. With its change in status, Ssembabule's health center was earmarked to be raised to the level of rural hospital with physicians, an operating theater, and generator power. The district now has two public health physicians (and additional health personnel, as per the chart below), an operating theater under construction, and three additional clinics, which bring the total number of clinics to ten.

Community Reliance on Traditional Providers and Drug Vendors. It is known on a local and national level that caretakers do not initially access care from trained health providers even in the most resource-rich towns and cities. Nationwide, according to the Ministry of Health, 90% of women first access health services through traditional providers and DVs.

In particular, caretakers very often rely on traditional sources of health care for the treatment of childhood malaria and diarrheal disease. Reliance on these providers is the result of confidence in the abilities of traditional providers and problems with clinic access and quality. Factors influencing this preference appear to include:

- Confidence in traditional providers because they are well known and a part of their community and tribal structure.
- Easy accessibility to traditional providers because they are members of the community.
- Supportive, positive attitudes.
- Availability of home visits and follow-up care.
- Long-term family relationships with specific providers.
- Shortage of health care providers in clinics.
- Distance to health care facilities.
- Negative attitudes and poor morale of health care providers.
- Frequent poor quality of services in clinics.

- Limited supplies and medications at clinics.
- Perception of clinics as being a “last resort” choice.

MIHV’s survey of more than 100 THs in the district revealed that caretakers seek TH services to treat diarrhea and malaria in children, and HIV/AIDS, mental illness, STIs, and malaria in adults.

DVs are also relied on by caretakers because of their:

- Doctor-like status in the community.
- Consistent supply of medications.
- Role in the provision of health services, especially where clinic services are unavailable.
- Role as dispensers of medication and advice even after caretakers visit a clinic.

In Ssembabule, approximately 300 DVs sell drugs. Although few DVs are formally trained and few of their shops are registered or regulated, DVs enjoy enormous respect: they are often viewed as having the expertise of a doctor. In an environment where access to health services is poor and clinics frequently experience drug shortages, caretakers go to DVs, not seeing any reason why they should not eliminate the “middle man”—i.e., the trained health provider.

In-depth Description of HH/C IMCI Implementation and/or Crosscutting Activity

Physicians	Medical Assistants	Nurses	Midwives	Lab. Techs.	Nurse Aides
2	3	8	6	1	30

Identifying Participants

To identify the most respected, best qualified potential participants, the project first interviewed key informants and held discussions with community leaders and women’s groups. In selecting this initial pool, the project emphasized locating providers who could influence not just caretakers but also other providers.

One hundred THs identified through community interviews and meetings were surveyed to determine what their treatment practices were, who their clients were, what they were charging for services, what form of follow-up care they provided, and so on. As noted above, the survey revealed that THs primarily see children for diarrhea and malaria care. On average, they saw three to four patients per day; their patients were loyal, making follow-up care possible. THs referred some cases, but did not have confidence in or have any connection with the official health care system.

DVs were extremely receptive to the goals and objectives of the project—sometimes even more so than THs because many had prior experience working with the project—as immunizers, for example, or community-based distributors. Overall, they were interested in increasing their knowledge and improving

their status in the community.

The project then held a meeting of identified THs and DVs at the subcounty level to introduce them to MIHV's child survival activities and to gauge their interest in properly diagnosing childhood illness, providing appropriate care, referring seriously ill children, conducting outreach to other providers, and mobilizing communities to improve health.

TH Training

Twenty-five of these THs self-identified to participate in the first training on disease recognition and referral. TH training was three days long, with periodic one-day refresher trainings conducted at the subcounty level approximately every six months. THs responded very positively to training: they appreciated being able to learn new things, being able to tell others that they had received training from the project, and being recognized by the project for their professional expertise and capability.

Trainings were designed and conducted by members of the DHT, with assistance from project staff, as a first step in building improved relations between traditional and trained providers. Improved relations involved recognizing common goals (so traditional and trained providers did not necessarily view each other as 'competitors'), recognizing limitations (THs could not successfully treat all cases and needed to refer seriously ill children, and clinic staff could not provide the sort of community outreach and follow-up routinely provided by THs), and developing mutual respect (clinic staff began to see, for example, that many TH practices have merit¹). THs shared their experiences with their peers, and an additional 25 THs requested and received training from the project, thereby doubling the number of participating THs.

TH Referral and Monitoring

In addition to involving district staff in training, this improved relationship was formalized through the establishment of a referral system and by involving clinic staff whenever possible in TH monitoring and supervision. Monitoring involves visiting THs in their homes, discussing patients, and reviewing diseases treated, referrals made, and follow-up conducted with families (to learn whether caretakers followed provider advice and whether children responded). Monitoring also involved (1) interviewing village leaders to learn whether they recognized an increase in TH skills and value; and (2) reviewing increases in referrals and overall usage of health clinics. Community leaders did not necessarily change their perceptions of TH skills, but they and health unit staff recognized a large increase in timely recognition of serious cases, referral, and usage of health units.

DV Training

Fifty DVs of the district's approximately 300 DVs were trained in the initial three-day training, which focused on proper care and referral of malaria. A key issue in training and monitoring was provision of partial courses of chloroquine. DVs wanted to sell partial courses to clients who could not afford a complete course of treatment, sometimes because they preferred any sale to no sale, sometimes because they believed partial treatment must be better than no treatment. As a result of intensive training and follow-up, DVs offered a commitment to refer clients who could not afford a full course of chloroquine treatment,

though of course this commitment was not always met. The project provided DVs with calendars and posters that displaying age-appropriate dosage information.

DVs were very committed to attending training and expanding their service provision role in their communities. Unlike other community workers, these cadres were not paid a stipend, and lost money whenever they closed their shop to attend a training. Nonetheless, they participated in the initial training and in subsequent one- to two-day trainings, which took place every three or four months.

DV Referral and Monitoring

As with THs, the district health team was involved in developing and administering DV training as well as in quarterly monitoring and supervision. Again, because many DVs had been community immunizers, they already had a working relationship with health units. DVs kept records of how much chloroquine they dispensed and to whom (who the client was, how old the client was, the course of treatment sold, any follow up or referrals made), which were reviewed during these monitoring visits.

It was very important in training and follow-up to help DVs recognize their limitations so they would be more likely to refer serious cases. Because of the status granted them by communities and the frequent absence of trained health care providers in the area, even the least qualified DV could sometimes overestimate his or her own knowledge and expertise. As part of training, the project stressed that it is acceptable for professionals to refer cases, to advise clients when they can be better served by a trained health care provider. The project also stressed that it is not good for business to give clients inaccurate advice. While DVs already knew this, it was important to discuss this issue openly and to reinforce professional norms.

Additional Activities

Community Mobilization by TBAs, THs, and DVs. Again using funds from the Conservation, Food, and Health Foundation, the project sponsored a large number of events, such as health fairs, to focus community attention on specific health issues and to provide related health services (e.g., Malaria Awareness Days, Micronutrient Days, National Immunization Days). These events were extremely popular and successful, largely as a result of the community mobilization work done by project TBAs, THs, and DVs. As noted above, involvement by these trusted cadres gave credibility and interest to these events. This was especially critical in the case of NIDs, given traditional suspicion of immunization.

While politicians or health care workers might encourage popular support for such events because they had been told to do so by their superiors, community providers had to be personally convinced of the importance of these events before they would endorse them. Project staff went to each village in the catchment area of a planned event, talked to THs, TBAs, and DVs, explained what they were planning and why, and answered questions. Generating their support was facilitated by the fact that these providers had received an overview of child survival interventions as part of their initial training.

Once involved, these providers were critical in mobilizing popular support. They went house to house (including on the day of the event), spoke at village council meetings, talked to people in markets, describing an upcoming event and why it was important. Caretakers trusted their opinion and were swayed by their

enthusiasm; they knew they could get straight answers from them, and in a manner they could understand. During the event, if trained, these providers might assist with service provision, administering polio vaccine, for example, or keeping records of who was immunized. DVs were particularly involved in Malaria Awareness Days, choosing venues, providing logistical support, and mobilizing communities to attend. Sometimes additional THs or DVs, not already involved in the project, would volunteer to be involved; they received a one-day training to facilitate their involvement.

Additional Training, Services, and Initiatives

Following the initial training, both THs and DVs expressed strong interest in receiving additional training so they could expand the role they played. THs received additional (basic) training in optimal breastfeeding and weaning practices; age-appropriate malaria treatment and referral; and immunization. As part of the malaria effort, THs were linked to trained DVs and given project-produced calendars that included proper dosage information. Interested THs were assisted to become distributors of condoms and/or bednets. This served communities which often had little access otherwise to such products, and it served THs, who were able to earn income from their sale.

DVs requested and received additional trainings on proper care and referral of diarrhea, HIV prevention through condom use, STD treatment (using DISH-packaged drugs), partner notification, first aid, bednet distribution, education about who in the household should use bednets, and provision of iron and multivitamins to pregnant women.²

As part of the initial training, participating DVs of their own initiative established a chartered DV Association to provide support and supervision to district DVs. Using government standards, the Association began working with the District Health Team to register and govern the activities of DVs in the district. Representatives go out with project or health unit staff to conduct DV monitoring visits. The Association also holds meetings for its 100 members and makes recommendations to the District Health Team regarding additional training needs. By working closely with district and clinic staff and communicating professional norms to its members, the Association plays a critical sustainability and quality-assurance role.

Methods, Results and Achievements

Results

The project learned from interviews with mothers and community leaders, and through review of referral forms for THs and DSKs, that the village-level referral system resulted in increased health system utilization. While much of the activities described in this paper were not funded by USAID, the baseline and final KPCs performed during the project period can also provide an indication of the success of these activities.

Recognition of malaria as a major health problem in children increased among caretakers from 33% in 1996 to 84% in 2000, probably the result of an increased understanding of the nature of the disease: caretakers no longer viewed it as a fever of unknown origin or the result of an evil spirit. A similar increase was demonstrated in women's recognition of malaria as a major health problem among women of reproductive age.

At the beginning of the project, 47% sought care for malaria at a drug shop, 32% at a health unit, and 11% from THs; by the final KPC, only 4% sought care at a drug shop, and 71% sought care at a health unit. Caretakers knowledge of appropriate chloroquine dosages for children increased from 10% to 22%, while their knowledge of appropriate dosages for themselves increased from 6% to 41%.

Use of ORS during the most recent episode of under-five diarrhea increased from 26% to 38%. Baseline understanding of diarrheal disease management included ORS (19%) and taking the child to a clinic (32%); by the final KPC, these had increased to 42% and 50%, respectively.

Materials and Tools Developed

In implementing this project component, MIHV and its partners developed training modules, adapting the existing MOH curriculum for TBAs and working with DVs and THs to revise existing curricula and develop new ones, depending on training needs. The project also developed print materials (calendars and posters), as stated above, to educate DVs, THs, and caretakers about age-appropriate chloroquine dosages, as well as dramas, songs, and poems to raise community awareness about diseases, disease symptoms, and special events. Tools developed included supervision tools, an instrument for referrals, and a record-keeping tool for DVs.

Household/Community Lessons Learned

- Initially, monthly community meetings and collaboration with key community members is essential to the planning and implementation of HH/C IMCI activities. Meetings must include sensitization trainings and capacity-building activities in order to develop community understanding, commitment, and ownership.
- Community IMCI cannot ignore the private sector, particularly in areas where access to public sector services is low, health unit resources are too limited to conduct community outreach and follow-up, and trust in community providers is high; in such circumstances child survival interventions may not succeed without the active support of such providers.
- Self-selection by potential participants can ensure selection of participants with greatest motivation.
- THs do not necessarily view child survival projects as “competition” or a threat to their livelihood or authority; treated respectfully, they can bring much enthusiasm, knowledge, client access, and credibility to a project.
- Opportunities to build relationships between community providers and district/clinic staff must be built into the program design.
- Involvement of clinic and district staff in the selection, training, and supervision of community providers is critical for sustainability.

- Although THs and DVs often have limited formal education, they are enthusiastic students; given necessary support, they can take great initiative to expand their IMCI role.
- Training materials must be simple but contain adequate and appropriate information to transfer necessary skills for disease recognition and referral.
- There is no reason to limit community provider involvement to existing client contacts. THs, TBAs, and DVs can play a proactive and critical role in mobilizing communities, even outside their presumed area of expertise (e.g., THs can be trained to deliver immunizations at NIDs). Cross training can provide community volunteers with revitalized commitment.
- Community education and referral is a necessary but not sufficient condition for full IMCI implementation. For IMCI to be fully implemented, health unit staff must also be appropriately trained and supervised and medications must be consistently available.

¹ For example, THs routinely gave children with diarrhea a modified but still effective ORS solution that contained herbs. To ensure proper care, trainers then emphasized the importance of boiling the water used in the solution and referring children who do not respond to this treatment.

² The project did not train DVs in ARI treatment as DVs were not supposed to be dispensing ARI antibiotics.

Improving Health: From the People - To the People

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Overview of the Project

PCI began a 3-year, USAID mission-funded child survival health activity in 1994 in marginal urban areas of Managua. The project, “Improving Maternal and Child Health Services in Five Neighborhoods of District IV, Managua, Nicaragua”, started in September 1994 and finished in August 1997.

PCI’s project addressed three of the four HH/C IMCI Intervention Options and resulted in significant improvements in knowledge and behavioral change while at the same time strengthened the formal and informal institutions that are critical to sustained health in the community.

Option 1: Closer links between health care facilities and the communities they serve

Health services: Prior to this project, the Ministry of Health (MOH) maintained a very ‘top down’ approach to service provision in communities with minimal information sharing, poor use of health volunteers and limited coordination with community stakeholders. PCI negotiated with the regional health authorities (MINSAL, District IV) to pilot a program that permitted greater flexibility in meeting community needs, allowed PCI to facilitate coordination between Neighborhood Health Posts and communities, and expanded the role of the community health project. Coordination between facilities and the community increased dramatically, volunteers became effective referral agents, and monthly analysis of cumulative data derived directly from households became used for ongoing planning.

Option 2: Improved care outside of health facilities (home treatment and community-based providers)

In addition to clinic-based service delivery, PCI expanded access to education and service delivery by using multiple entry points whereby information could be received, health conditions monitored and people engaged to improve their own health. These entry points included health promoters, schools and mothers’ clubs.

Health promoters

Health promoters or *brigadistas* are individuals 15 years or older that work voluntarily to improve the health of their communities. Prior to this program, their participation had been limited to little more than assistance in community mobilization during immunization campaigns organized by the MOH. PCI provided eight months of training to these *brigadistas*, emphasizing the critical role they play within the health system. Each *brigadista* was assigned 10 to 15 households comprised of children under two and /or households with pregnant women.

An innovative household-based health monitoring and analysis tool called the Maternal-Child Health Calendar (MCHC) was developed by PCI for this project. This simple but powerful instrument was provided to the mothers to track important health events throughout each month. While it served to increase caretaker awareness and management of health activities, it also served as a didactic tool during home visits carried out by brigadistas.

Schools

PCI developed a “child-to-child” program using a highly participatory educational methodology that allowed children to teach other children how to care for their own health as well as the health of others through games, songs and stories. PCI worked with four different primary schools, training selected students and teachers. Teachers were helped to integrate basic health messages within the school curriculum and children were given the knowledge and tools to disseminate those messages within the community and households. This program not only helped to increase access to health knowledge but also was formative in developing future health promoters and medical professionals. Many children who participated, in fact, expressed a desire to be promoters, nurses and doctors when they grow up.

Mothers’ clubs

Mothers’ clubs were initiated by PCI and brought pregnant women and mothers with infants together for monthly meetings. The purpose of these meetings was to deliver necessary health information in a direct, systematic and entertaining fashion. Participatory methods were used including games and role-playing. Meetings were often facilitated by brigadistas and periodically involved children from the child-to-child program as well as health professionals. While meetings were designed to convey essential information regarding pre and post natal care all in one meeting, mothers often returned multiple times because they enjoyed the meetings so much.

Option 3: Integrated promotion of key family practices critical for child health and nutrition

PCI designed an integrated program in order to address several, inter-related health behaviors underutilized within the communities but critical to improving the health of children and mothers. The program focused on 16 behaviors in eight priority areas: 1) immunizations; 2) diarrhea disease; 3) respiratory illness; 4) growth monitoring and promotion; 5) nutrition and vitamin A; 6) breastfeeding; 7) maternal health; and 8) family planning. Brigadistas received eight months of training in total with additional follow-up refresher trainings. They were also trained in information systems and use of the MCHC.

Cross-cutting activities

PCI used the KAP survey for baseline, midterm and final evaluations. The maternal-child calendars became a health-monitoring tool used at the household, community and clinic levels. At the community level, brigadistas and clinic staff used the aggregate data monthly to assess community health and plan activities. At the household level, the tool was used to help the brigadista in targeting specific health messages and in

assisting mothers in monitoring the health status of their children.

In- Depth Description of HH/C IMCI Intervention and Crosscutting Activities

Option 1: Closer links between health care facilities and the communities they serve

Health Services

The five urban marginal neighborhoods targeted for this project have access to medical attention through a health center, a health post or small neighborhood medical post. The medical post is a health unit managed by the community that is accessible to the population. Prior to this project, the neighborhood medical post would remain open for only a few hours per day. Doctors offered curative care only with no link to the communities and staff demonstrated little interest in working in the neighborhood.

PCI helped to link the community health volunteer worker with the MOH staff at the local level through a participatory baseline, regular meetings with the community, major involvement of the volunteers in supporting their clinic, the on-going health education training program for the MOH staff and the brigadistas.

This project was the first in Nicaragua to establish a MOH-supported, community-based MCH program within the neighborhood health post. During the first year of work, the health district's authorities supported project activities in a very limited way. As a consequence, activities were more directly coordinated between the PCI-supported neighborhood coordinators and the Health Post medical staff. In the second year, the MOH authorities were more supportive, mainly due to the results demonstrated. Responses from medical staff who were initially skeptical, are demonstrated in the following quotes:

“My personal experience as a community doctor was that I didn’t know what to do. PCI taught me how to develop health chronologies, quantify coverage and know how we’re doing”

“I did my work but had no control. I now have more referrals and can better detect problems in my neighborhood.”

Health Post Doctors

Improvements in access to services were noted by the population served. Clinics were open all day, offered MCH programs and were supported with basic medical equipment. Improvements were also noted in client satisfaction with the quality of services received.

In order to address a serious problem of malnutrition and vitamin A deficiency detected at the start of the project, the Health Center decided to support Neighborhood Health Posts by sending a nutritionist once a week. The community also responded by identifying other alternatives, such as opening new comedores infantiles (infant feeding centers), reactivating those that had ceased to exist, and implementing hydroponic family gardens.

Option 2: Improved care outside of health facilities (home treatment and community-based providers)

Health Volunteers

In Nicaragua, there has been a broad movement of selecting and training Health Volunteers to increase community-based health services since the 1980s. Traditionally though, these volunteers were used to support specific, wide-scale activities organized by the Ministry of Health, such as immunization and hygiene campaigns. They were not involved in active, daily community health promotion. In most cases, volunteers selected had low levels of formal education, were extremely shy, and had no comprehensive health training. This information was very important in the consideration of a training design for the Health Volunteers.

PCI strengthened the previously weak Health Volunteer network by developing a methodology for working with Health Volunteers systematically, with quality training and supervision mechanisms in place. This methodology takes into account different training steps during the entire year with new goals and challenges for the volunteers covering eight different health interventions. PCI began working with previously MOH- selected brigadistas who also helped to recruit other community members. PCI sought to achieve a ratio of 1 brigadista for every ten families with children under two or pregnant women. In total, 111 brigadistas were trained to cover a beneficiary population of 1,834 children and 773 pregnant women.

Brigadistas that were selected demonstrated a strong sense of commitment to their own community in promoting maternal-child health care and have been trained in topics related to preventive health and emergency interventions. Health intervention training and fieldwork were combined in order to put into practice acquired knowledge and skills. Once training was completed, brigadistas were assigned families and committed themselves to carrying out planned activities at various venues including the Neighborhood Health Posts, Mothers' Clubs and Home Visits.

Educational materials were developed with health volunteer input to assist them in providing educational, discussion-based lectures. Combining graphic IEC materials with interpersonal communication allowed parents to more fully comprehend the educational messages and more effectively discuss them with other members of the family.

During this period, communities were still very polarized by the war and by the political factions that grew out of it. Through their work on this project, brigadistas had put aside their political differences and conflicts. Over time, they developed a great sense of appreciation and maturity for team work, and became more aware that they were all pursuing a common goal of improvement for themselves, their own families and their communities. Sentiments such as those below were frequently expressed:

Child-to-Child program at the Primary Schools

PCI decided to work with schools because of the potential for learning and modeling during the formative years. It was felt that it would be important to change negative health practices at a young age, especially since older siblings have a role in educating and caring for younger children in Nicaragua.

Within the schools two strategies were developed: one addressed the teachers and the other targeted students. Working with the teachers was especially important, as the project needed them as allies to support the “Child-to-Child” Program. PCI also felt it important to capitalize on the many opportunities teachers have at school to introduce educational topics related to basic health care, which are often overlooked. Teachers were trained and given assistance in how to incorporate health topics in their curriculum. Some of them volunteered as monitors and helped to organize the children participating in the program.

Children aged 10 to 14 years old, from fourth through sixth grades of primary school, were recruited with parental authorization. They received training in the project interventions and other topics they were interested in discussing (such as violence, drugs, children’s rights), and they learned how to effectively convey health messages. The key strategy was teaching the children in an innovative and fun way – or to “learn by playing”. PCI developed a Child-to-Child manual to guide this process which was based on lessons learned in a previous project in Acahulinca (1991-1994). Children’s stories, dramatizations/role playing, songs, puppet theater, health murals and other educational techniques were used.

The most important achievement related to teachers’ involvement was the increased awareness about health topics both at the school and community levels. Teachers have also strengthened their ability to address basic health care issues, especially those directly related to personal hygiene.

“Schoolteachers are proud because children come to school with combed hair, clean nails, teeth and clothes.”

Teacher

Teachers also consider they have established better communication with parents about health topics. They say that they take advantage of the parent meetings in order to address certain health issues, such as the importance of using the Health Post, household hygiene and waste disposal, etc.

Students working in the child-to-child program were very enthusiastic and committed to the work they did. They felt they had overcome an initial feeling of shyness, and most of them developed important communication and leadership skills within the larger population. Feedback from the children included:

“Now I can give recommendations to my mother about correct use of ORS and household fluids.”

“We are giving advice to the mothers about how to care for their children.”

Child-to-Child Participants

Mothers' Clubs

Mothers' clubs were formed in July 1995. Initially, they were facilitated by the PCI technical coordinators of the neighborhoods. Gradually, various responsibilities were assigned to the brigadistas until they were capable of performing all of the activities involved in the club without the need for technical support.

Key to this program was making the clubs accessible and ensuring that it was both fun and interesting for the mothers. Initially recruitment was done by the brigadistas. But soon after, word spread and new and expectant mothers came without recruitment. Key messages regarding pre-natal care, recognition of obstetrical complications, breastfeeding and weaning practices were discussed through the use of interactive games and dramatizations that stimulated conversation.

Option 3: Integrated promotion of key family practices critical for child health and nutrition

Upon completion and analysis of the baseline survey, data was used to design an educational methodology for integrated health promotion. The methodology was designed to introduce household-based health education in a more integral way than had been done in the past. At the beginning, the volunteer training was focused in just one area of intervention per month, and the recipients received a focused health theme. After the volunteers passed the basic training and were able to manage the general knowledge of each intervention, the project started to train them in how to integrate messages, so that all interventions were combined and the mothers received from the brigadistas a more integral education about child and maternal health. In all venues (schools, mothers' clubs, households and clinics) the project sought to focus on 8 areas and 16 knowledge and behaviors associated with improved maternal-child health, and looked for ways of linking complementary topics. For example, discussions regarding diarrhea prevention were combined with nutrition and hygiene, and respiratory disease discussions were combined with living conditions and feeding practices.

The maternal-child health calendar aided in promoting a more integrated and holistic approach to addressing household health needs by ensuring topics were tied to events that occurred in the household during the month related to all 8 areas. Moreover, IEC material was developed and validated in the field focusing on appropriate behaviors associated with breastfeeding and young child feeding; immunizations; prevention of diarrhea disease and cholera; and treatment of respiratory infection. These materials were distributed to the families and explained during the household visits by the *brigadistas*.

The health information system (HIS) for the project was composed of two sub-systems, the MOH information system and the community HIS. The MOH information system at the neighborhood health post was used to gather monthly information of the medical attention and vaccination information when provided. Prior to this project, this information was sent to the higher level without it "cycling back" to the local level. Through negotiations with the MOH, PCI was able to encourage them to 1) increase the range and accessibility of health services provided, and 2) reorganize their information systems with the idea that the data must be analyzed and discussed at the local level in coordination with the community. Information was

organized in a monthly chronological series of the main diseases and health services delivered, to facilitate the monthly analysis. An immunization tracking system through immunization cards was also established.

The community HIS allowed for information produced at the local level to be analyzed and managed at this level in conjunction with the MOH and the community. The purpose of this was to strengthen local decision-making. This model promoted the decentralization process that the MOH had committed to in the national health policy.

“I like to participate in all of it because we all respect each other even though we are from different parties, I feel good to provide my home for the benefit of our community. I feel like we’re working well.”

“There is unity in action in working for and with the community.”

Brigadistas

Health volunteers distributed the MCHC to pregnant woman and mothers with children under two years old. The MCHC offered the opportunity to obtain information about basic health care and important health events related to pregnant women and children less than two years of age using a calendar as a guide for documenting sick events. They were filled out by the mothers and supervised and collected monthly by Health Volunteers at their homes.

Each volunteer has a number of mothers to follow-up with every month. Volunteers reviewed the calendar with mothers to observe if it was filled out appropriately, provided health advice to mothers related to the problems expressed by the events notated in the calendar, and strengthened the mother’s ability to use the calendar. At the end of each month, the *brigadista* removed the sheet pertaining to the month just completed. The calendar information was then aggregated and tables produced to show trends throughout the year. Every month the volunteers discussed the findings together as a group, and then acted upon them in coordination with the MOH staff. The analysis of the health situation at a local level was particularly useful when comparing data produced by the community health information system with that produced by the MOH information system, as this analysis showed MOH statistics to be substantially under registered.

From the point of view of the general population at the community level, it was felt that the health services were more accessible and more efficient as a result of this project. There was also raised awareness about personal and family health care and an increased consciousness about community health care.

The direct beneficiaries of the project in the five neighborhoods are 944 children under one year of age, 899 children whose ages range between 1 and 2 years, for a total of 1,843 children. In addition, direct beneficiaries include 6,131 women of reproductive age and about 773 pregnant women.

Methods, Results and Achievements

The data was collected during the baseline, midterm and final evaluations. The following information was used to assess the project:

- Bibliographical review and analysis of the project's documents such as: reports, evaluations, educational materials, methodological designs for workshops, etc.
- Individual and collective interviews through focus groups with: health personnel, health volunteers, teachers, children participating in the Child-to-Child Program, Project Team, etc.
- Observation of some of the activities carried out by the project: Mothers' Groups, home visits, puppet shows, dramatizations/role-plays, etc.
- KAP 30 cluster surveys.

The KAP surveys allowed the project to establish a baseline and evaluate at the project's end its effectiveness in achieving behavioral change in 16 targeted areas: immunization, diarrhea, nutrition and growth monitoring, women's health and acute respiratory infection. The other process and quantitative methods mentioned above were used regularly to monitor progress and make necessary adjustments to program activities. For each of the 16 behaviors, ambitious but achievable targets were established. By the end of the 3-year project desired behaviors had doubled, tripled or quadrupled in most of the key areas. Eleven out of the 16 targets were achieved with three out of the remaining four having made significant gains.

Perhaps the most important achievement during this three-year project was to demonstrate the feasibility and success of a multiple-intervention, integrated approach to maternal-child health. This methodology helped to exploit key networks in the community such as Health Volunteers, teachers, students and the population in general in order to forward important health objectives. (See Attachment 1 for entire list). While the program concluded in 1997, a visit to the project site in January 2000 revealed that the Health Volunteers have maintained contact with the health units, 3 or 4 *brigadistas* are in charge of the health unit on a permanent basis, and they are conducting patient referrals to the health units in a verbal form given that the MOH does not provide any format. The majority of the *brigadistas* are working again in the national health campaign, so the role now is reduced compared with the one they play during the project. This is mainly due to the lack of funds of the MOH to provide training on a permanent basis. There are 8 mothers' clubs functioning with mothers trained by the project that now are counselors. This strategy was introduced also in other neighborhoods by the MOH. The maternal-child health programs are functioning in the clinics and the MOH was able to expand this to others places. They are self-sustaining and there is high demand for them among the population. The MOH calendar is not functioning due to a lack of resources to produce it and the limited MOH capacity to link with private companies to provide the calendar for free as part of an advertising campaign. The homes of volunteers selected continue offering the oral rehydration salts.

HH/C IMCI Lessons Learned

- The most important lesson is related to the validation of the methodological design of the project. The multiple-intervention, integrated approach using participatory education as a key strategy was successful. It reached different members of the families through a broad range of activities in various settings in order to improve maternal and child health in the participating communities. It was felt, however, that the project was not designed to thoroughly engage fathers. Future applications need to integrate activities aimed at the father, or the male member of the family.
- Differing organizational characteristics, needs and preferences among different Health Volunteers were found to be essential to this approach. This aspect improved confidence and effectiveness, which are important to organizational strengthening and sustainability.
- Concerning clinical service delivery, the most important lesson was the importance of building and maintaining successful coordination between Health Volunteers and the Ministry of Health. This required systematic communication and joint analysis of activities. This strategy has demonstrated that it is feasible and beneficial to build and maintain positive relationships between the community and the Ministry of Health. The multiple-intervention methodology included some practical components in its coordination with the Ministry of Health. It is important to combine practical coordination at the local level, open communication at the departmental level and general coordination at the national level (SILAIS, Ministry of Health). This multiple level coordination enhances follow-up from the Health Center level, which facilitates sustainability. It also encourages more clear definition of policies and strategies related to maternal and child health at the institutional level.
- Conducting situation analyses at a local level to compare data from the community health information system to data from the MOH information system was especially useful in strengthening community self-confidence and in establishing a permanent relationship with the MOH staff.
- A lesson related to the Health Volunteers Network is the importance of on-going analysis, planning and evaluation within the network to keep it organizationally strong. This type of analysis works best when it emphasizes the impact of benefits of volunteer work at the community level in order to deepen commitment in terms of number of work hours and activities taken on. This analysis strengthens self-esteem and leadership of health volunteers, as well as their credibility among the population. Many times after successful workshops, enthusiasm leads volunteers to define high-performance work plans, which are sometimes difficult to achieve or maintain systematically without monitoring and support systems built-in.

- The Child-to-Child Program has also provided important lessons to children, teachers, health volunteers and families. Working within this context to promote organization among children and within the community seems to be extremely important in order to facilitate links between different strategies and health interventions. These linkages could also increase teachers' commitment with health topics at the school level.
- Project activities provoked an increased demand for services among the population. This situation must be taken into account when planning for human resources and for time available for each of the interventions. It is important that medical doctors at the Health Posts have the time to do field work, such as visiting schools, homes, etc. in order to increase their exposure to the more practical elements of the educational approach utilized. This seems very simple, but it is common to see doctors only at the Health Posts, emphasizing only clinical issues.

Analysis of Community IMCI Implementation Options Framework

The paper "Reaching Communities for Child Health and Nutrition" adequately encompasses the ways in which communities can be engaged to meet their own health needs. It could be developed into a good management tool for designing HH/C IMCI programs.

A few changes are recommended to more accurately describe HH/C IMCI. It would appear that Option 3 should really be a requirement rather than an option if we are to refer to what we do as IMCI (emphasis on the 'I'). As such, Option 3 is a necessary condition or strategy when implementing Option 1 and 2 rather than a separate application of HH/C IMCI.

Second, a multi-sectoral approach may have two separate applications. One is the complementarity of other sectors to improved health as is described in the paper (i.e.; water and sanitation, income generation, etc.). Another application is the use of other sectors as vehicles for driving an IMCI agenda. An example would be how PCI used the school system to increase dissemination of key IMCI messages.

Partnerships for C-IMCI in Uganda

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Introduction

This paper is intended to give a brief overview of the various ways in which PVOs and NGOs (Non-Governmental Organizations) are working in partnership with the Government of Uganda, at national and district levels to promote the implementation of Community IMCI. It presents the NGO steering committee as one viable mechanism for fostering the partnership between government and NGOs and outlines the role that BASICS is playing to promote this partnership.

In this paper, the terms NGO and PVO are used interchangeably and refer to non-governmental, voluntary, not for profit organizations involved developmental objectives and activities. Some are international in origin e.g. CARE International, World Vision, AMREF, etc. while others are local in origin e.g. TASO, FLEP, etc. NGOs are registered with the NGO board and are recognized by government as significant partners in development. In general, their areas of operation vary from covering several districts to covering only single districts or parts of a district.

Due to the decentralization process in Uganda, the planning and implementation of most activities including those in the health sector is done at district level. The national (central Ministry) level is charged with setting policies and guidelines as well as making resources available to districts. Likewise, although many of the NGOs have their headquarters at the central level, most of their detailed planning and implementation activities are carried out at district level and at the national level, they have a more limited role.

The importance of the role being played by NGOs in promoting health in Uganda is recognized in the national health policy and the health sector strategic plan. The health sector strategic plan envisages the strengthening of the on-going collaboration between government and NGOs for health (e.g. through secondment of staff from Government to NGOs, disbursement of funds to NGO health units through districts and sharing of other resources). This would be through the development of service contracts and increasing subventions to the NGOs. The strategy for C-IMCI also recognizes the important role played by NGOs in reaching communities and households, in a more comprehensive way than government services can. It provides for involvement of NGOs in implementation of C-IMCI from national level down to the community level. The Ministry of Health (MOH) recognises the NGO community as a resource for district capacity building for the implementation of C-IMCI.

In February 2000, over 40 NGOs and MOH personnel and partners interested in the IMCI strategy and its community component, participated in a meeting which was organized by World Vision and Africare Uganda and sponsored by BASICS II project. The meeting aimed at:

- enhancing NGO understanding of community – IMCI activities and opportunities in Uganda.
- Highlighting NGO community-based experiences that are important for the implementation of community – IMCI in Uganda.
- Discussing possible linkages between the NGO community and the MOH in implementation of IMCI.
- Developing plans to increase the NGO participation with MOH to expand C-IMCI in Uganda.

The meeting raised a lot of questions regarding coordination between NGOs and MOH, integration of IMCI with on-going NGO activities, what would be the most appropriate role of NGOs in IMCI and how this can be sustained, how NGOs can scale up their activities and how the quality of the IMCI related activities could be monitored.¹ The meeting also made several recommendations, key among which was the need to form an NGO steering committee.

In April 2000, a follow on meeting was held between NGOs, MOH and other partners and an NGO steering committee was formed. The committee which comprises: World Vision, CARE International, AMREF, AFRICARE, PLAN International, FLEP and ADRA as the NGOs as well as representation from WHO, UNICEF and MOH will be operational for a one year period after which it will be reviewed and any required changes made.

The NGO steering committee has a major responsibility of developing a plan to address the key questions and issues raised regarding further integration, coordination, sustainability, quality and scaling up of C-IMCI within the NGO community and between the NGO community and it's MOH counterparts. It does this by frequent meetings to discuss the issues of concern, making information available to members and other NGOs and bringing issues of concern to the MOH.

Since it's inception, several meetings of the steering committee have been held focussing on improving coordination between the NGOs and MOH and also on getting NGO input into MOH decisions, guidelines and programs. The NGO steering committee has been active in influencing decisions of the national IMCI working group.

A memorandum of understanding, between the MOH and the NGO steering committee has been prepared. In this MOU, the NGOs and the MOH agree to collaborate in the development and implementation of activities for the household and community component of IMCI in Uganda in order to avoid duplication of services. The NGOs have an obligation to coordinate with each other and with the MOH in order to strengthen capacity for C-IMCI. They are committed to joint training, support supervision, and monitoring, raising of resources and participation in the formulation of district health plans. The government on the other hand has several responsibilities, including building NGO capacity for IMCI implementation.

Although the operations of the NGO steering committee have had a slow start, it has been actively involved at the national level decision making for C-IMCI.

NGO – Government Partnerships at National Level

At the national level, the NGO steering committee is playing a key role in ensuring that NGO views and inputs are made into MOH decisions, guidelines and programs through participation in the National IMCI working group. The NGO steering committee is represented in the national IMCI working group which is a multi-sectoral working group responsible for guiding the implementation of CIMCI activities in the whole country. Concerns of the NGOs are discussed in the steering committee and then put forward to the working group. This ensures that NGO concerns and suggestions are heard. Through the NGO steering committee and the IMCI working group, NGO and government have been involved in:

- Joint planning for C-IMCI implementation
- Capacity development for planning and implementation enhancement
- Technical cooperation (e.g. in development of guidelines for C-IMCI implementation)
- Advocacy for funding support
- Facilitation of linkages
- Improved interagency communication (through the NGO steering committee, government policies can easily reach NGOs)

Partnerships at District Level

At the district level, the NGOs are involved in joint planning with the districts for C-IMCI and in actual community level implementation of activities. The specific activities implemented vary from NGO to NGO and even across districts depending on the district and NGO priorities and plans. However, the activities being implemented by the NGOs cut across all the four-implementation options and are targeted at one or several of the key behaviors. Below are some examples of activities being done by NGOs for the different implementation options²:

- Closer links between health units and the communities they serve: This is being promoted mostly by religious based NGOs and other NGOs that operate health units and are involved in outreach activities e.g. Church Of Uganda, ADRA. Other NGOs are supporting the training of health workers to increase their skills e.g. AMREF and CARE International.
- Improved care outside health facilities – As far as the NGOs are concerned, the major focus has been on nutrition improvement in homes, h/education for behavioral change, recognition of danger signs and early referral. Almost all the NGO are doing this to varying extents. A few NGOs are now getting involved with improving care in the private sector (clinics, drug shops and traditional healers) e.g. Africare in Ntungamu district.
- Integrated promotion of key family practices – this is an area of strength for NGOs in Uganda as many of them were involved in the STI program and HIV/AIDS prevention programs where they were promoting key practices. Now they are using the same knowledge, skills and structures for C-IMCI. Many NGOs are involved in the implementation of the Nutrition and early childhood development project.

- Multi-sectoral approach to child health and development is being carried out by various NGO e.g. Action Aid with area development programs as well as various local NGO, which focus at poverty eradication.
- Cross cutting activities – e.g. Advocacy for allocation of resources, for child rights e.g. Red Barnet & Red Barna, for education of girls, for bye-laws; Developing tools for PRA.

Behavior of Main Indicators During different Phases of the Project Implementation

No	Indicator Objectives	Baseline	Midterm	Final	Target
1	Increase from 53% to 83% the amount of children between 12 and 23 months that have been vaccinated correctly	53%	69%	84%	82%
2	Increase from 44% to 59% the amount of mothers that know that their child must be immunized against the measles when they are 9 months old.	44%	41.3%	61%	59%
3	Increase from 51% to 69% the amount of children younger than two years old that receive oral dehydration and that are treated for diarrhea during their episodes.	51%	52.2%	61%	69%
4	Increase from 27% to 67% the amount of mothers with children under the age of two that can at least identify one dehydrating symptom.	27%	44%	57%	67%
5	Increase from 44% to 75% the amount of mothers with children under the age of two, that look for the help of qualified health workers (brigadistas, home based or health post) for their children with acute diarrhea.	44%	51%	67%	75%
6	Increase from 58% to 70% the amount of mothers with children under the age of two, that show an adequate practice of feeding their infants during their episodes of diarrhea.	58%	65%	58%	70%
7	Increase from 10% to 25% the amount of children being exclusively breastfed until they are 4 months old.	10%	38%	38%	25%
8	Increase from 25% to 60% the amount of mothers with children under the age of two, who have growth and development control cards for their infants	25%	45%	81%	60%
9	Increase from 11% to 33% the amount of mothers with children under the age of two that know that vitamin A is good for the health and well being of their child.	11%	28%	47%	33%
10	Increase from 33% to 47% the amount of mothers with children under the age of two that recognize the foods that contain vitamin A.	33%	72.3%	74%	47%
11	Increase from 0% to a 50% the amount of children under the age of five that receive two 200,000 UI vitamin A complements each year	0%	45%	S.D.	50%
12	Increase from 58% to 66% the amount of fertile women (15 years – 45 years) that use family planning methods to space their births	58%	60%	67%	66%
13	Increase from 29% to 60% the amount of pregnant woman that receive at least one prenatal control	29%	36%	98%	60%
14	Increase from 62% to 70% the amount of pregnant woman who have been correctly immunized with TT	62%	73%	72%	70%
15	Increase from a 51% to 60% the amount of mothers with children under age two, that know at least one alarm signal of the acute respiratory infections that require medical attention from a health post.	51%	56%	64%	60%
16	Increase from a 60% to a 76% the amount of women that look for the help of a qualified health worker (brigadier, base home, health post) for him to take care of her child with ARI.	60%	57%	80%	76%

Source: Baseline, Mid-term and final surveys coordinated by PCI team

NOTE: Information not collected for Indicator 11 for final survey

The Role of BASICS II Project

BASICS II project is working at the national level and in 6 districts to promote C-IMCI implementation. The overall objective in the six districts is to help scale up implementation and impact of child health interventions, linking government, district local government and NGO / CBO (community based organizations) programs.

The main activities include:

- Increase effective and expanded implementation of HH/C IMCI strategy in the six districts to increase service utilization and changed behaviors.
- Increase effective NGO growth promotion activities.
- Increase involvement and effectiveness of NGOs in immunization as part of comprehensive child health.
- Support the MOH to develop a national common reference framework and tools for the HH/C process through integration of tools and best practices utilized by the NGO community.

BASICS II has been involved in:

- Supporting the NGO steering committee at National level.
- Providing technical assistance and support for joint govt./ NGO planning and implementation of CIMCI – at district level e.g. Kumi district, Masaka district.
- Facilitating the sharing of information and experiences between government and NGOs.
BASICS has been involved in sensitization & orientation of NGOs on the national C-IMCI strategy. It has also carried out an assessment of NGO activities in the 6 districts with a view of identifying possible areas of collaboration among NGOs and with Government. The findings will be shared with various NGO stakeholders and MOH.
- Advocacy for increase recognition of the role of NGOs – all 6 districts where BASICS is working now have NGOs in their IMCI working groups.

Challenges and Limitations for the Partnerships

- Heavy reliance of most NGOs on outside / donor funding – there is only limited local resources being generated by the NGOs. This puts limitations of what the NGOs can do, especially where their current donor funding doesn't cover community child health activities. As a result of the partnership with MOH, several possible solutions are being discussed and look promising. This includes MOH & districts to provide some funding or other resources for activities being implemented by NGOs e.g. training materials, IEC materials, equipment & logistics for outreach services e.g. transport, ice –packs, weighing scales for growth monitoring. BASICS II project has a critical role in facilitating the linkages between specific NGOs and MOH for this to occur.

- MOH sub-contracting some of its activities to NGOs such as the Uganda community based health care association UCBHCA etc.
- The technical capacity of NGOs is usually limited to one or two specific areas and there is need for capacity building for the NGOs before they can be fully involved in C-IMCI.
- Even with the NGO steering committee in place, coordination among the various NGOs is still weak and requires strengthening.
- Monitoring & supervision of activities implemented by NGOs in communities by the government is weak as no proper structure / mechanism has been developed. In most cases, the NGOs supervise their own activities and only report to the districts and Ministry of health. There is an urgent need to establish a joint monitoring system.
- Financing the activities of NGO steering committee still needs to be streamlined. Currently this is being covered by: the individual NGOs represented on the steering committee (staff time and transport), the Ministry of Health and BASICS.
- NGOs are by their nature time and indicator bound- the MOH and districts are much more flexible and getting the two to work together is sometimes frustrating.
- Proper documentation of the many activities being implemented by NGOs and sharing it with partners.
- Influencing the design of future activities of NGOs so that C-IMCI is an integral part of these activities.

Conclusion

In conclusion, NGOs are important partners in the implementation of C-IMCI in Uganda at both national and district level. Their roles cut across the four implementation options and are targeted and one or several of the 16 key behaviors, depending on the NGO. Despite the many challenges facing the partnership, the formation of an NGO steering committee offers a viable option for strengthening the partnership.

¹ A full report of the meeting is available from BASICS office.

² This is based on an assessment of NGO activities done by BASICS in 6 districts.

APPENDIX B

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APPENDIX C

SUMMARY OF IMCI 101

Summary of IMCI 101

The Child Survival Technical Support Project (CSTS) convened IMCI 101 on January 16, 2001, as a precursor to the HH/C IMCI workshop. IMCI 101 was a day-long overview of the basic principles of IMCI as well as recent research and tools. Summaries of the day's presentations follow.

Overview of the Development and History of the IMCI Strategy

Michel Pacqué (Child Survival Technical Support Project), for WHO/World Bank

Significant progress has been made in the reduction of child mortality, but 10.8 million children under the age of five still die every year. Forty nine percent of these children die from one of four major causes: respiratory disease, malaria, measles, and diarrheal diseases. There is a grave inequity in the quality of care received between rich and poor, urban and rural, tertiary and primary care. This inequity of treatment is compounded by the poor quality of care at all levels.

What is IMCI?

The objectives of IMCI (Integrated Management of Childhood Illnesses) are to significantly reduce global mortality and morbidity in children under five and to contribute to the healthy growth and development of children. IMCI focuses on reducing mortality and morbidity associated with the major causes of disease in children under five: diarrhea, respiratory diseases, malaria, and measles.

In traditional, vertical health care programs, national programs conduct a number of disease-specific courses, using separate guidelines and technical materials for each disease. It is up to the health worker to attend all of these courses and then integrate these guidelines internally.

The IMCI strategy promotes integration of vertical programs at many levels. IMCI allows different departments in the Ministry of Health and technical programs to work with professional societies, universities and others to plan and implement the IMCI strategy. Health facilities receive support and essential resources for the prevention and treatment of major childhood illnesses. Health care providers can attend one training course, rather than an array of disease-specific courses, and can then provide integrated care for sick children. IMCI engages families and communities by promoting appropriate home care and safe, supportive environments for healthy growth and development. This multi-level integration ultimately benefits children, who receive holistic care as a result of the IMCI strategy.

Benefits of the IMCI strategy

IMCI is more efficient and cost-effective than vertical programs. The increased efficiency of the IMCI strategy saves resources and leads to improved quality care and utilization of services. Because resources are reallocated to rural levels as well as urban levels, implementation of the IMCI strategy improves equity.

IMCI focuses care on major health problems in children, thus decreasing morbidity and mortality of children under five. It is a flexible strategy that can be adapted to major child health issues in a given context. This approach may lead to a significant impact on children's health.

Presentations of IMCI Guidelines

René Salgado (John Snow, Inc.)

WHO/UNICEF provides an eleven day training course in the IMCI guidelines that combines a large volume of classroom work with hands-on clinical practice. Although doctors may take the course, the course is geared towards first-level health care workers, such as nurse-auxiliaries.

The course teaches participants to assess, classify and treat sick children; refer seriously ill children and administer pre-referral treatment; counsel caretakers about danger signs and when to return for follow up care; check immunization status; provide nutrition counseling; and, when appropriate, carry out feeding assessments.

Rene Salgado described the IMCI course and led participants through exercises similar to those in the 11-day course. The IMCI case management process outlines is as follows:

1. Assess
2. Classify
3. Identify treatment
4. Provide treatment solutions
5. Refer when necessary
6. Provide counseling

Through videotape demonstrations, participants learned how to assess and classify cases of pneumonia and diarrhea. To assist in the practical exercises, each participant received the WHO/UNICEF Management of Childhood Illness chart booklet used in the WHO course.

Health System Strengthening for IMCI

Paula Tavrow (Quality Assurance Program)

This section answered the question of how a strong health system introduces standards. In its broadest sense, a standard is a statement of the degree of quality expected. Standards should be valid, reliable, clear, measurable, and realistic. Strong health systems introduce standards in the way they define the desired quality, work to improve the quality of performance, and monitor the quality.

Typically, each level (national, district, facility, and community) has primary responsibility for different activities. For example, developing and adapting guidelines may be primarily the responsibility of the national level, while the district is responsible for communicating these standards, the facility is charged with obtaining client input, and the community provides incentives for following the standards. However, the involvement of multiple levels in each activity achieves greater results and creates a much stronger health system.

Benefits and Challenges of IMCI

IMCI offers numerous potential benefits including more accurate diagnosis, treatment, and referral as well as better patient monitoring and follow up. Because IMCI treats the whole child, there are fewer

missed opportunities for immunizations and Vitamin A distribution. IMCI training enables workers to communicate more effectively with caretakers and offer more effective counseling on nutrition and breastfeeding.

However, IMCI also poses several challenges. First, providers don't regularly perform IMCI. Discussions among providers in Uganda, Kenya, and Zambia have revealed that within three months of training, half of the providers no longer perform IMCI. The half that do so, perform IMCI rarely.

Second, trained providers make many errors in classifying illness, creating a second challenge facing IMCI. Providers who were observed in Kenya, Zambia, and Uganda missed about 1/3 of severe classifications leading to about 20% to 40% of children getting incorrect treatment. Severe illnesses are most frequently misclassified: severe disease, severe malnutrition, and severe dehydration.

Third, IMCI training is costly and requires follow-up. In Uganda, Kenya, and Zambia, the cost of the initial training course ranged from \$450 to \$750 per trainee. The large number of people at each facility who require IMCI training multiplies this cost. Not only do all providers who see sick children need IMCI training, but also the facility senior management needs training or orientation in order to be supportive of IMCI.

Interventions to strengthen health systems for IMCI

The Quality Assurance Program (QAP) tested three interventions to strengthen health systems for IMCI. In Kenya, facility-based problem-solving teams were formed to identify and reduce barriers. Facility teams were given a problem for which they selected their own solutions using simple quality tools to implement the solutions. Solutions implemented by the teams in Kenya included efforts to procure IMCI drugs, clocking-in registers, on-the-job training, changes in patient flow, shared workloads, monthly meetings, regular practice of IMCI, and proper duty allocation.

A second intervention tested by QAP involved regular supervision and feedback in Niger. Quality and regularity of supervision are important for performance improvement and supervisors need incentives and peer pressure to monitor regularly. With this in mind, simple assessment and feedback tools were developed that focused on provider performance.

QAP worked with BASICS on an ERPA assessment tool (Rapid Health Worker Performance Evaluation). The tool has four parts: direct observation of the health care provider, a client exit interview, a provider interview, and a review and inventory of the facility record. Additionally, feedback was solicited in the district workshop. The results of the supervision and feedback demonstrated that IMCI compliance decreased between October 1997 and December 1998.

A third intervention tested by QAP was the use of job aids. QAP knew that providers who use job aids are more likely to perform IMCI correctly, unfortunately the current job aid, the chart booklet, is not user-friendly and is avoided by many providers.

To address this, a new job aid was created in Zambia. The job aid helps providers more clearly connect the symptoms they assess to the appropriate classifications. Currently in draft form, the new job aid was evaluated in December 2000.

Much remains to be done to address the key challenges of IMCI and increase IMCI compliance. More pilot testing of approaches is needed.

Improving IMCI Training with a Computer-Based Program

Marina Budeyeva (University Research Corporation)

Computer-Based Training (CBT) was developed by The Quality Assurance Project, and was first implemented in Uganda. CBT programs are interactive and self-paced and may be both shorter and more cost-effective than traditional training. As an added benefit, training programs can be copied and shared among a large number of users. The program can also serve as a reference for up-to-date learning and is a good source for information and documents.

A study team lead by Paula Tavrow field-tested the IMCI CD-ROM in Uganda.¹ A cost analysis showed that the cost per trainee of CBT was almost 20-25% less expensive than the traditional course (omitting development and hardware costs). Facilitators found the course less taxing and participants seemed to prefer the CBT course, even though none of the participants had ever used computers before the training. The study further concluded that new CBT courses might lead to increased knowledge and retention of information.

Those interested in further information are invited to contact QAP.

IMCI Complementary Course Development

Beth Gragg (World Education)

World Education, based in Boston, has 50 years of experience in adult education programs in 38 countries, including the United States. Currently, World Education is developing programs for IMCI in Nicaragua, Honduras, and El Salvador.

World Education's IMCI Complementary Course is designed for facilities-based health practitioners with lower levels of literacy. The people who come to these courses generally have a sixth grade education, two years of medical training, little access to reading materials, and little or no in-service training. Because many live in isolated areas, they are frequently overlooked for in-service training. Consequently, they have a lot of practical experience but little in-service training.

The course design is based on IMCI objectives, guidelines, and materials and relies more on participation than reading. Non-formal techniques are used to find out what participants know, build on their current skills, let them practice new skills, and evaluate their learning. The learning is based as closely as possible to the reality of what the health care workers do.

It is important to remember that one size does not fit all. The course must be adapted to the IMCI protocol of the country where it is conducted and course design must respond to the needs of the participants. Additionally, proper equipment, drugs, and supervision must be in place, or participants will not be able to apply their IMCI skills.

The complementary course builds the capacity of stakeholders, because stakeholders are trained to perform site audits, run curriculum development seminars, and train trainers. All supervision and follow-up are carried out with the goal of deliberate skills building.

An Overview of the Uganda IMCI Impact Study

George Pariyo (Johns Hopkins University)

Johns Hopkins University and Makerere University, Uganda conducted the Uganda IMCI Impact Study in collaboration with the Ministry of Health. The study was prompted by the need to evaluate the implementation of IMCI and measure its success in changing behavior and decreasing childhood illness and mortality. The study had three objectives:

1. Document the impact of the introduction of IMCI on child mortality.
2. Document the change in process and outcome indicators in health facilities (both NGO and public facilities), communities and households as a result of IMCI.
3. Determine the opportunity costs of human resources, equipment, and finances needed for IMCI and determine if a greater benefit could have been achieved if resources had been used differently.

Results from the Baseline Survey Health-Seeking Behavior

The study found that few families use mosquito nets to prevent malaria. Less than eight percent of children slept under a net the night before the study, and less than nine percent of the nets used had ever been treated with insecticides.

Eighty-two percent of the mothers sought medical care for children who had difficult breathing. This was by far the highest rate of care seeking for a danger sign. However, mothers were more likely to seek medical care within 24 hours for a fever than for difficult breathing.

A majority of caregivers rely on western medicine for fevers, whether the child remains at home or is taken to a health facility. Forty-two percent of caregivers obtain drugs from a drug shop; the next most common source of drugs is medication leftover from previous illnesses (25%)

Most caretakers take their children to private clinics and drugstores. Only 17% went to a health facility, and roughly 2% sought care from NGOs. Most caretakers took their children to whichever facility was closest to them. Caregivers often indicated that they would go to a health facility if it were closer, as the care is perceived to be better there. The average travel time to a public health facility was 15 minutes.

Costing

Cost is the most often cited reason by caretakers for not seeking referrals. Other factors included lack of transportation or lack of permission from the head of the household.

The study concluded that the household costs of seeking care are much too high. Although most people walk to health facilities, transport and lodging still account for a relatively high proportion of the costs of seeking health care.

Highlights of the Health Facility Survey

Preliminary results from the Health Facility Survey in eight districts revealed that workers trained in IMCI were more likely to check the respiratory rate of a child with a cough or difficult breathing than workers who were not trained in IMCI. IMCI-trained workers were also more likely to check for

dehydration in children with diarrhea, check weight cards, give correct feeding instructions, and refer children when appropriate.

General Observations

Low utilization is a general problem. A large proportion of children are still managed by health workers who are not trained in IMCI. Those workers who are trained in IMCI do not strictly follow the IMCI case management algorithm. Facilities lack the drugs and equipment for IMCI; most facilities have first-line drugs, but lack second-line drugs and drugs for pre-referral treatment. Additionally, many facilities lack essential equipment for IMCI, such as chart booklets, laminated forms, and mother's cards.

Infant and Child Mortality

Both infant and child mortality steadily decreased in the fifteen years preceding the survey. Several factors were found to be key mortality determinants. Female babies generally experience lower mortality than male babies and babies born to younger mothers (under 40) experience higher mortality rates than babies born to mothers who are forty years of age or older. First-order births are at highest risk for mortality, followed by birth orders seven and higher. Second- and third-order had the lowest risk. Children of mothers who had at least a secondary education enjoy the best probability of survival, while children born to mothers with no education were at the highest risk of death.

What is the PVO's Role in the IMCI Initiative Partnership?

Alfonso Rosales (Catholic Relief Services; CORE IMCI Working Group Co-chair)

In the health sector, WHO describes a partnership as a means to bring together a set of actors for the common goal of improving the health of populations based on mutually agreed upon roles and principles.

PVOs can play a prominent role in the IMCI partnership. PVOs can participate in policy development at the global, regional and national levels. There are opportunities, but PVOs have to be ready to take them and they must be pro-active in pursuing them. PVOs can offer technical support in the adaptation process and in material development. Because of their presence in the community, PVOs are in a position to help strengthen and promote links between health facilities and the community. Finally, PVOs can offer valuable resource support in the national implementation process.

Community IMCI: Two paradigms

Community IMCI (C-IMCI) is currently in a developmental stage. The international public health community does not share a single, common definition of community IMCI. There are two main paradigms of C-IMCI: IMCI in the Community, and Community-Based IMCI.

IMCI in the Community

IMCI in the Community is a top-down approach centered primarily at the health facility. The commu-

nity is one of three components, but is largely passive. The main focus is on “improving family and community practices” by improving communication from the health facility to the families and the community.

The IMCI in the Community approach presents some challenges. This approach relies on the existence of accessible health facilities, and there is currently an access problem. As this approach also relies on effective communication to families and communities, a change in the attitudes and behaviors of the first-level health facility workers and more contact between the first-level health workers and the children’s caretakers is needed. Improved communication between the health worker and the caretaker could promote appropriate care-seeking behavior and treatment compliance.

Community-Based IMCI

Community-Based IMCI is a horizontal approach that, in contrast to IMCI in the Community, is not focused on the health facility but on the community, who implement the approach. This approach defines specific health care roles for home, community, and health facility and facilitates links between the health facility and the community.

The main focus of this approach is on strengthening household and community actions to address prevalent childhood diseases. As health facilities are only visited by 17% of the community, resources are not primarily focused on improving the skills of the health facility workers as they are in the IMCI in the Community approach.

This approach also has its challenges. Community-based IMCI necessitates a paradigm shift from an “exclusive” public health to an “inclusive” one that actively involves the community. Physicians must learn not to think as physicians, but as health workers. Providers also need to have a global, regional, and national commitment to a community focus; an emphasis on “home-level” promotion and prevention in the IMCI strategy; and a community IMCI process that includes an introduction phase, early implementation phase, and expansion phase.

It is not a question of one or the other - the two approaches actually complement one another. While IMCI in the Community improves the quality of services at the health facility, Community-Based IMCI improves access and problem-solving capacity at the community level.

Suggested Roles of the NGO Community in IMCI

Larry Casazza (World Vision; CORE IMCI Co-chair)

Planning and Management

Major NGOs within a country should join national level working groups in order to help influence national IMCI policy. In the districts, NGOs may serve as the focal point for high level expertise. NGOs can develop and sustain supervisory systems, and take an independent role in service evaluation.

Service Delivery

It is estimated that up to 50% of health care delivery in some countries derives from the NGO sector. NGOs can work to provide higher quality in facilities and staffing; improved drug availability; concentration

on special and under-served populations; and documented examples of effective management and community development practices.

Training

NGOs can support IMCI training by providing sites and facilities for training. Further, NGOs can train their national and international staff in IMCI. Including government staff in NGO training may ensure consistency.

Research and Development

Often, NGOs are asked how they do things, and especially how they mobilize communities. NGOs do not have enough documentation to meet this need and should document their efforts and successes in IMCI. Operational research is needed on alternative models of care in small populations and NGOs can test materials and methods in areas of controlled quality. They can also test new approaches, particularly in community action. IMCI should be included in multi-sectoral development approaches.

Lessons-Learned

- Use health facilities for continuing education meetings and sharing health information records.
- Assist Community Health Committees to assume non-clinical supervisory functions.
- Train health facility staff in supportive supervision.
- Model effective supervision methodologies to Ministry of Health staff through joint supervision.
- Promote supervision and joint problem solving of health workers and CHV in the community and assist in the development of relationships of mutual appreciation and interdependence.

Review of IMCI Component in Child Survival Grant Submissions

Nitin Madhav (USAID)

The Child Survival Grants Program has seen a rise in the number of applications containing an IMCI component. In 1999, 39% of the applications received included an IMCI component. However, several applications were not funded because of program gaps identified in the grant proposals.

John Murray, a medical epidemiologist, reviewed the 19 applications that involved IMCI. Those submitting applications involving an IMCI component are urged to read his observations. They can be found in *A Review of IMCI Programming from CSXVI Grant Applications*, which appears as an annex in *An Analysis of Scores and Reviewer Comments from CSXVI Grant Applications, September 11, 2000*. This document is on both the USAID and CSTS Web sites. Anyone with questions about the RFAs or the application process is urged to contact USAID.

APPENDIX D

FINAL AGENDA

Reaching Communities for Child Health: Advancing PVO/NGO Technical Capacity and Leadership for HH/C IMCI

Workshop Goal

To enhance the capacity of CORE PVOs to take greater leadership in the development and implementation of national and district HH/C IMCI Programs

Workshop Outcomes

- Clear understanding of the PVO/NGO role in the development and implementation of HH/C IMCI Programs.
- Increased understanding and application of lessons learned, better practices, and approaches that can be used in HH/C IMCI programming.
- Increased understanding of processes that will enhance PVO/NGO leadership roles in HH/C IMCI at national, district, and community levels.
- HH/C IMCI implementation options tool that is related to ongoing PVO/NGO activities.

Day One: Options for Implementing Community IMCI

8:15 – 9:00 WORKSHOP REGISTRATION	
9:00 - 10:30 Welcome and Introduction Panel	
Introduction, Goals, Outcomes, Logistics Personal Expectations	Rene Salgado Facilitator
Welcome Address: Core's Role in C-IMCI	Larry Casazza CORE
Welcome Address: Importance of PVOs in C-IMCI	Al Bartlett USAID
C-IMCI Implementation Options: A Proposed Tool	Peter Winch JHU / BASICS II
Questions and Answers Wrap Up	
10:30 – 11:00 BREAK	
11:00 – 12:00 Panel 1	
C-IMCI Implementation Option #1: Closer links between health care facilities and communities they serve	
Moderator: Chris Drasbek, PAHO	
Introduction to C-IMCI Implementation Option 1 and Linkages with PAHO CHW training package	Chris Drasbek PAHO
CARE India The Indian Experience in Developing an IMCI Training Package for Basic Health Workers	Sanjay Sinho CARE
CRS Cambodia Co-management and Co-financing: A model to increase health facility utilization	Lori Dostal CRS/Cambodia
Questions and Answers Wrap-Up	

12:00 – 1:00 Panel 2 C-IMCI Implementation Option #2: Improved Care Outside of Health Facilities Moderator: Rob Northrup, HOPE	
Introduction to C-IMCI Implementation Option 2	Rob Northrup
CARE Kenya Partnering with communities and CHWs for IMCI Case Management	Vincent Orimba CARE/Kenya
MIHV Uganda Partnering with Traditional Healers and Drug Sellers in Uganda	Jolene Mullins MIHV
Questions and Answers Wrap-Up	
1:00 – 2:00 LUNCH	
2:00 – 3:00 Panel 3 C-IMCI Implementation Option #3: Integrated Promotion of Key Family Practices Critical for Child Health and Nutrition Moderator: Alfonso Contreras, BASICS II	
Introduction to C-IMCI Implementation Option 3	Alfonso Contreras
PCI Nicaragua Improving Maternal and Child Health Services in 5 Urban Communities in Managua	Leonel Arguello PCI/Nicaragua
SC Vietnam Sustained positive deviant child care practices and their effects on child growth in Vietnam	David Marsh SC
Questions and Answers Wrap-Up	
3:00 – 3:30 Panel 4 C-IMCI Implementation Option #4: Multi-sectoral approach to child health and development Moderator – Vincent Orinda, UNICEF	
Introduction to C-IMCI Implementation Option 4	Vincent Orinda
Moderated discussion on this intervention	Rene Salgado
3:30 – 4:00 BREAK	
4:00 – 6:00	Small Group Discussions Divide into 4 small groups - One Group for each C-IMCI Intervention Option. Discuss and make recommendations to present to plenary tomorrow morning on key questions for overall tool and for group specific intervention option: <ol style="list-style-type: none"> Does this “tool” of 4 options help you conceptualize and plan appropriate C-IMCI interventions with your partners? Should anything be added / deleted / changed to make this “tool” clearer for you to use with your partners? Is this specific “option” clearly defined? If not, what needs to be added? deleted? changed?

Day Two: Successful PVO/NGO Approaches Critical

9:00 – 10:00 Welcome and Introduction Panel – Day Two	
Welcome and Summary of Day One Overview of Day Two: Importance of Cross-Cutting Activities	Rene Salgado
Small Group Report Outs: Summary of Day One discussions (3-5 minutes / group) Highlight group recommendations	4 Small Group Facilitators
Group Discussion: Next Steps on Tool	Rene Salgado
10:00 – 11:00 Panel 5 Strategies to Mobilize Communities Moderator: Remi Sogunro, WHO/AFRO	
Introduction: Importance of Community Mobilization to C-IMCI	Remi Sogunro
SC Bolivia Impact of a CB HIS in Bolivia (Linkage with Intervention Option 1)	Lisa Howard-Grabman, and Cynthia Willis SC and Emory University
WV South Africa Use of PLA and other Key Tools to Mobilize Communities in Bergville, RSA (Linkage with Intervention Option 2)	Larry Casazza World Vision
Questions and Answers Wrap-Up	Remi Sogunro
11:00 – 11:30 BREAK	
11:30 – 12:30 Panel 6 Sustaining Community-Based Practitioner Programs Moderator: Eric Sarriot, CSTS	
Introduction: Working with CHWs - Sustainability Issues	Eric Sarriot
CARE Peru Linking Public Health Services and the Community in Rural Peru (Linkage with Intervention Option 1)	Luis Espejo CARE/Peru
CRS El Salvador Community Support for Improving Child Health: Promotion and Network Sustainability (Linkage with Intervention Option 3)	Alfonso Rosales CRS
Questions and Answers Wrap-Up	
12:30 – 1:30 LUNCH	

1:30 – 3:00 Panel 7 Partnerships for Scale: Critical Processes Moderator: Al Bartlett, USAID/G	
Introduction Working as Partners to Achieve Scale	Al Bartlett
JSI/PVOs Nepal C-Based IMCI : Partnerships to Increase Access, Quality and Scale of Childhood Pneumonia Treatment through FCHVs	Penny Dawson JSI/Nepal
BASICS and PVOs in Uganda Partnerships for C-IMCI in Uganda	C. Abeja-Apunyo BASICS II/Uganda
PAHO and PVOs Working with PVOs in the Americas – a regional strategy	Alfonso Rosales CRS & CORE IMCI Working Group
Questions and Answers Wrap-Up	
3:00 – 3:30 BREAK	
3:30 – 6:00	Small Group Work Divide into 4 groups. Each group discusses key questions and records key observations and recommendations and next steps. Discuss and make recommendations to present to plenary tomorrow morning on group topic: Group 1 Develop recommendations and next steps for finalizing the C-IMCI Implementation Options Tool and its utility. Group 2 Develop recommendations for PVO innovation and action / operational research (as related to options in the C-IMCI Implementation Options Tool) critical to moving child health forward. Group 3 Develop recommendations for increasing scale-up of community - district child health programming. Group 4 Develop recommendations for accelerating PVO involvement, leadership and advocacy for child health at national levels.

Day Three: Increased Understanding of Processes that Will Enhance C-IMCI

Panel 8 C-IMCI Implementation Options Tool	
Welcome Review of Day 1 and 2 Purpose of Day 3	Rene Salgado
Small Group 1 Recommendations on C-IMCI Implementation Options Tool	Small Group 1 Delegate
Plenary Discussion Next Steps to Finalize and Enhance Use of Tool	
9:45 – 11:00 Panel 9 PVO C-IMCI Leadership through Innovation Moderator: Massee Bateman, EHP	
Introduction: Critical Areas for Innovation	Massee Bateman
Project HOPE–Dominican Republic Collaboration of Public and Private Sector in IMCI	Karen Cuevas, CHP Director
Freedom from Hunger Field Agent Centered Management to Improve Message Development and Communication	Ellen Vor der Bruegge FFH
Small Group 2 Recommendations on Innovation and OR	Small Group 2 Delegate
Plenary Discussion Questions and Answers Wrap-Up Key Question: Where is innovation most needed?	
11:00 – 11:30 BREAK	
11:30 – 12:30 Panel 10 PVO Leadership Roles in C-IMCI Moderator: Kate Jones, USAID/BHR/PVC	
PVO Leadership Roles in C-IMCI: An Update on PVO roles at country level	Kate Jones
Small Group 3 Recommendations Child Health Linkages at the Community and District Level	Small Group 3 Delegate
Small Group 4 Recommendations Leadership for Child Health at the National Level	Small Group 4 Delegate
Plenary Discussion Questions and Answers Wrap-Up Key Question: How can PVOs / NGOs be more effective in achieving child health for greater numbers of children?	
12:30 – 1:30 LUNCH	

1:30 – 3:00 Panel 11 Advocacy for Child Health Moderator: Flavia Bustrero, World Bank	
Importance of Advocacy for Community Approaches to Child Health	Flavia Bustrero
How to Advocate for Community Approaches to Child Health and Nutrition	Nelly Temple Brown WHO/DC
Questions and Answers Wrap-Up Key Question: What are advocacy tools and approaches that PVOs can use to advance HHC/IMCI?	
2:30 – 3:15 Panel 12 Global Next Steps to Advance HHC/IMCI Moderator: TBD, WHO/G	
Discussion Talk with groups of 4-6 people around your table for 10 minutes on key question: What's needed at country level for acceleration of HHC/IMCI implementation?	Facilitator
Plenary discussion of next steps	Moderator
3:15 – 3:30 Conclusions, Evaluation and Farewell Moderator: Rene Salgado	

APPENDIX E

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The driving force of this workshop, and one of its most promising outcomes, was the development of a dynamic operational framework for community IMCI. It provides a clear structure for assessing programs, planning future programming, and advocating for the resources necessary to fully operationalize HH/C IMCI.

The framework describes three requisite elements, which target the many influences on health promotion and care-seeking behavior:



Element 1: Improving partnerships between health facilities and the communities they serve

Element 2: Increasing appropriate, accessible care and information from community-based providers

Element 3: Integrated promotion of key family practices critical for child health and nutrition

These elements and the framework's multisectoral platform can be used as a communication and planning tool by PVOs, government, and the donor community.